DOCUMENT RESUME

ED 441 203 CG 030 008

TITLE	Common Psychosocial Problems of School-Aged Youth: Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment. Guidebook.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Bureau of Maternal and Child Health and Resources Development.
PUB DATE	1999-01-00
NOTE	249p.
AVAILABLE FROM	School Mental Health Project, Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563. Tel: 310-825-3634; Fax: 310-206-8716; Web site: http://smhp.psych.ucla.edu; e-mail: smhp@ucla.edu.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC10 Plus Postage.
DESCRIPTORS	Adolescents; *Behavior Problems; Children; Elementary Secondary Education; *Emotional Problems; Intervention; *Learning Problems; Mental Disorders; *Mental Health Programs; School Community Relationship; School Psychologists; Schools; Social Problems; Student Problems

ABSTRACT

In schools, youngsters with serious emotional and learning problems usually are assisted under the auspices of "special education." Of course, many students with behavior, learning, and emotional problems don't meet the criteria for special education. Their needs must be addressed through support programs and other accommodations. This guidebook is designed to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools. It provides a framework and strategies to guide schools as they encounter common psychosocial problems in students. It is designed as a desk reference aid. An introduction provides an overview of mental health in schools. Part One stresses ways to keep the environment in perspective as a cause of certain types of problems. Part Two frames the full range of programs that allow a school and a community to address psychosocial problems. Part Three covers five of the most common syndromes students manifest and schools agonize over: attention problems; conduct and behavior problems; anxiety problems, affect and mood problems; and social/interpersonal problems. Part Four explores ways to increase a school's capacity to prevent and ameliorate problems. Part Five provides additional sources of information, including agencies and organizations that can provide further information and support. (Each section contains numerous references.) (JDM)

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Mental Health in Schools
Center
Training and Technical Assistance

GUIDEBOOK:

Common Psychosocial Problems of School Aged Youth:

Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment

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Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health

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Mental Health in Schools Center Training and Technical Assistance

UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

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*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

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What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units*. These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

• E-mail us at	**smhp@ucla.edu**
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• Phone	(310) 825-3634
• Write	School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

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All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

If you know of something we should have in the clearinghouse, let us know.

HRSA

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Preface

School systems are not responsible for meeting every need of their students. But when the need directly affects learning the school must meet the challenge.
Carnegie Council on
Adolescent Development, 1989

Estimates of the number of school aged children with emotional problems vary. Incidence and prevalence figures are controversial, with estimates ranging from 2-3% to 22% (Costello, 1989; Doll, 1996; Knitzer, Steinberg, Fleisch, 1990). The numbers increase when those referred to as at risk are included (Dryfoos, 1990, 1994; Hodgkinson, 1989). Research suggests, however, that there are a considerable number of false positive misdiagnoses (i.e., the labeling of youngsters who do not have true disabilities/disorders). What is clear is that schools can accomplish their goal of teaching only when they have addressed the psychosocial problems that interfere with students' learning.

In schools, youngsters with serious emotional and learning problems usually are assisted under the auspices of "special education." Of course, many students with behavior, learning, and emotional problems don't meet the criteria for special education. Their needs must be addressed through support programs and other accommodations.

This resource provides frameworks and strategies to guide schools as they encounter common psychosocial problems. *It is designed as a desk reference aid.*

After an introductory overview of mental health in schools:

- Part I stresses ways to keep the environment in perspective as a cause of certain types of problems.
- Part II frames the full range of programs that allow a school and community to address psychosocial problems.
- Part III covers five of the most common "syndromes" students manifest and schools agonize over:
  >attention problems
  >conduct and behavior problems
  >anxiety problems
  >affect and mood problems
  >social/interpersonal problems
- Part IV explores ways to increase a school's capacity to prevent and ameliorate problems.
- Part V provides additional sources of information, including agencies and organizations that can provide further information and support.

To provide a normalizing perspective, the descriptions adopted are those used in the 1996 American Academy of Pediatrics' manual (*The Classification of Child and Adolescent Mental Diagnoses in Primary Care -- DSM-PC*). This framework differentiates developmental variations, problems, and disorders in ways that provide a good basis for identifying minor developmental differences and early symptoms so that minor concerns can be prevented from escalating into major disorders. Following this discussion, the focus is on intervention -- emphasizing use of "accommodations" as a first strategy and the role of empirically supported treatments.

At the UCLA *Center for Mental Health in Schools*, we have developed a variety of materials relevant to specific problem areas. For example, Introductory packets are available on request dealing with such topics as *Learning Disabilities, Pregnancy Prevention, Substance Abuse,* and *Dropout Prevention.*

Of course, identifying problems is a minor part of the role of school and community professionals in optimizing a student's ability to profit from education. Restructuring support services into more effective units to address problems and promoting school wide programs for prevention are essential. A great deal of the work of our center focuses on this part of school reform. For example, we have materials on *Assessing to Address Barriers to Learning; Screening and Referral; Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections;* and *What Schools Can Do to Welcome and Meet the Needs of All Students and Families.*

Relevant Center materials are described in Part V along with information on how to acquire them.

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Introduction:

Mental Health in Schools

Why do schools have any mental health related programs?

One reason, of course, is that legal mandates require certain mental health services for students diagnosed with special education needs (Duchnowski, 1994). Another is that school policy makers and practitioners recognize that social, emotional, and physical health problems and other major barriers to learning must be addressed if schools are to function satisfactorily and students are to learn and perform effectively (see Dryfoos, 1994,1998; Flaherty, Weist, & Warner, 1996; Tyack, 1992). Despite widespread acknowledgment of the need for interventions related to mental health and psychosocial concerns, such activities are not a primary item on a school's agenda. This is not surprising. After all, schools are not in the mental health business. Their mandate is to educate. Activities not directly related to instruction often are seen only as taking resources away from their primary mission.

An extensive literature reports positive outcomes for psychological interventions available to schools. Some benefits have been demonstrated not only for schools (e.g., better student functioning, increased attendance, less teacher frustration), but for society (e.g., reduced costs related to welfare, unemployment, and use of emergency and adult services). At the same time, it is clear that school-based applications must be pursued cautiously. With respect to individual treatments, positive evidence generally comes from work done in tightly structured research situations; unfortunately, comparable results are not found when prototype treatments are institutionalized in school and clinic settings. Similarly, most findings on classroom and small group programs come from short-term experimental studies (usually without follow-up). It remains an unanswered question whether the results of such projects will hold up when the prototypes are translated into widespread applications (see Adelman & Taylor, 1997a; Durlak, 1995; Elias, 1997; Weisz, Donenberg, Han, & Weiss, 1995). Available evidence is insufficient to support any policy that restricts schools to use of empirically supported interventions, and the search for better practices remains a necessity. At best, the work accomplished to date provides a menu of promising prevention and corrective practices.

In large school districts, one finds an extensive range of preventive and corrective activity oriented to students' problems. Some programs are provided throughout a district, others are conducted at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at-risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. With specific respect to mental health, the full range of topics arise, including matters related to promoting mental health, minimizing the impact of psychosocial problems, managing psychotropic medication, and participating in systems of care. It is common knowledge, however, that few schools come close to having enough resources to handle a large number of students with mental health and psychosocial problems. Most schools offer only bare essentials.

Excerpt from:

H. Adelman & L. Taylor (1998). Mental Health in Schools: Moving forward. *School Psychology Review*, *27*, pp. 175-190.

As school districts move to decentralize authority and empower all stakeholders at the school level, and as managed care takes hold, a realignment is likely regarding the governance of pupil service personnel, their involvement in school governance, and collective bargaining. Ultimately, this realignment and efforts to improve cost-effectiveness will have a major role in determining how many such interveners there are at a school (Hill & Bonan, 1991; Streeter & Franklin, 1993).

Professionals with psychological training are expected to bring to school settings understanding of key intervention considerations (see Table 1). These include a focus on psychosocial, developmental, and cultural factors that facilitate or interfere with positive functioning and interventions that emphasize attitude and motivation change, system strategies, use of "best fit" and "least intervention needed" approaches and more. Such knowledge and related skills are needed in assisting students with mild-to-moderate learning, behavior, and emotional problems and in addressing targeted problems (e.g., school avoidance and dropout, substance abuse, gang activity, teen pregnancy, depression). Such a range of expertise also is essential in working with the diversity of backgrounds and the wide range of individual and group differences found among students, their families, and school staff. (For those wanting to read more about the considerations outlined in Table 1, see our syntheses in Adelman & Taylor, 1993b, 1994).

As they assist teachers, specialists with mental health orientations tend to focus upon students seen as problems or as having problems. The many functions of such specialists can be grouped into three categories: Direct services and instruction; Coordination, development, and leadership related to programs, services, resources, and systems; and Enhancing connections with community resources (Adelman & Taylor, 1993b, 1997b; Taylor & Adelman, 1996). Prevailing direct intervention approaches encompass identification of the needs of targeted individuals, prescription of one or more interventions, brief consultation, and gatekeeping procedures (such as referral for assessment, corrective services, triage, and diagnosis). In some situations, however, resources are so limited that specialists can do little more than assess for special education eligibility, offer brief consultations, and make referrals to special education indoor community resources. Well-developed systems include mechanisms for case coordination, ongoing consultation, program development, advocacy, and quality assurance. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth, though relatively few resources usually are allocated for such activity.

Because resources are so limited, efforts to address barriers to learning and enhance healthy development are not seen as the sole province of professionals/specialists. Professionals trained to provide mental health interventions have a special role, but so do all staff hired by a school, and so do students, family members, community agency personnel, volunteers, and so forth. All can and should be part of efforts to address mental health and psychosocial concerns (see Adelman & Taylor, 1993b; Taylor & Adelman, 1996).

All efforts are meant to contribute to reduction of problem referrals, an increase in the efficacy of mainstream and special education programs, and enhanced instruction and guidance that fosters healthy development. When given the opportunity personnel addressing mental health and psychosocial concerns can contribute to program development and system reform as well as helping enhance school-community collaborations (Adelman, 1993; Adelman & Taylor, 1997b; Rosenblum, DiCecco, Taylor, & Adelman, 1995).

Table 1
Some Key Intervention Considerations

☐ Timing of interventions

A. Primary prevention
(including a major emphasis on promoting opportunity and wellness)
B. Early-age
(including prereferral interventions)
C. Early after onset
(including prereferral interventions)
D. After the problem has become chronic

☐ Form of intervention for individuals, groups, and families—accounting for diversity and resiliency

A. Information giving
(e.g., printed materials, use of media and advanced technology, directions and information for obtaining assistance, information phone lines)
B. Assessment and information gathering
C. Didactic instruction and skill development (e.g., social, performance, and transition skills; career planning; drug and sex education; parenting classes)
D. Mobilizing and enhancing support for student (e.g., initiating support groups, adopt-a-student, developing special status roles, involving the efforts of others, including staff/systemic support, parent/family support)
E. Work and recreation programs
F. Systemic changes to enhance program efficacy (e.g., school improvement team participation)

☐ Scope of interventions

A. Open enrollment programs
B. Crisis response
C. Prescribed services—narrowly focused, short-term
D. Prescribed services—narrowly focused, continuing as long as the need exists
E. A prescribed comprehensive approach

☐ Contexts for intervention

A. School rooms, offices, recreation facilities
B. School clinics or health centers
C. School family service centers
D. Entire school used as a focal point for creating a sense of community
E. Home visits and involvement with community-based organization (including the courts)
F. Referral to community resources

☐ Some basic intervention guidelines

A. Balance current emphasis on discrete problems with appreciation for underlying commonalities (less categorical emphasis; more cross-disciplinary activity and training)
B. Personalize intervention (e.g., account for psychosocial, developmental, and cultural factors; match motivation and capability)
C. Use the least intervention needed (e.g., most normalized environment, least restrictive environment, community-based—preferably school-based, "best fit")
D. Design comprehensive, integrated approaches
E. Prioritize with reference to consumer needs, not service provider predilections

Note. The important role advanced technology can play in all of this is beginning to be appreciated but is still to be realized.

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I. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

E (E<--->p) E<--->P (e<--->P) P

Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

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Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

> ***There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.***
>
> ***Nicholas Hobbs***

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

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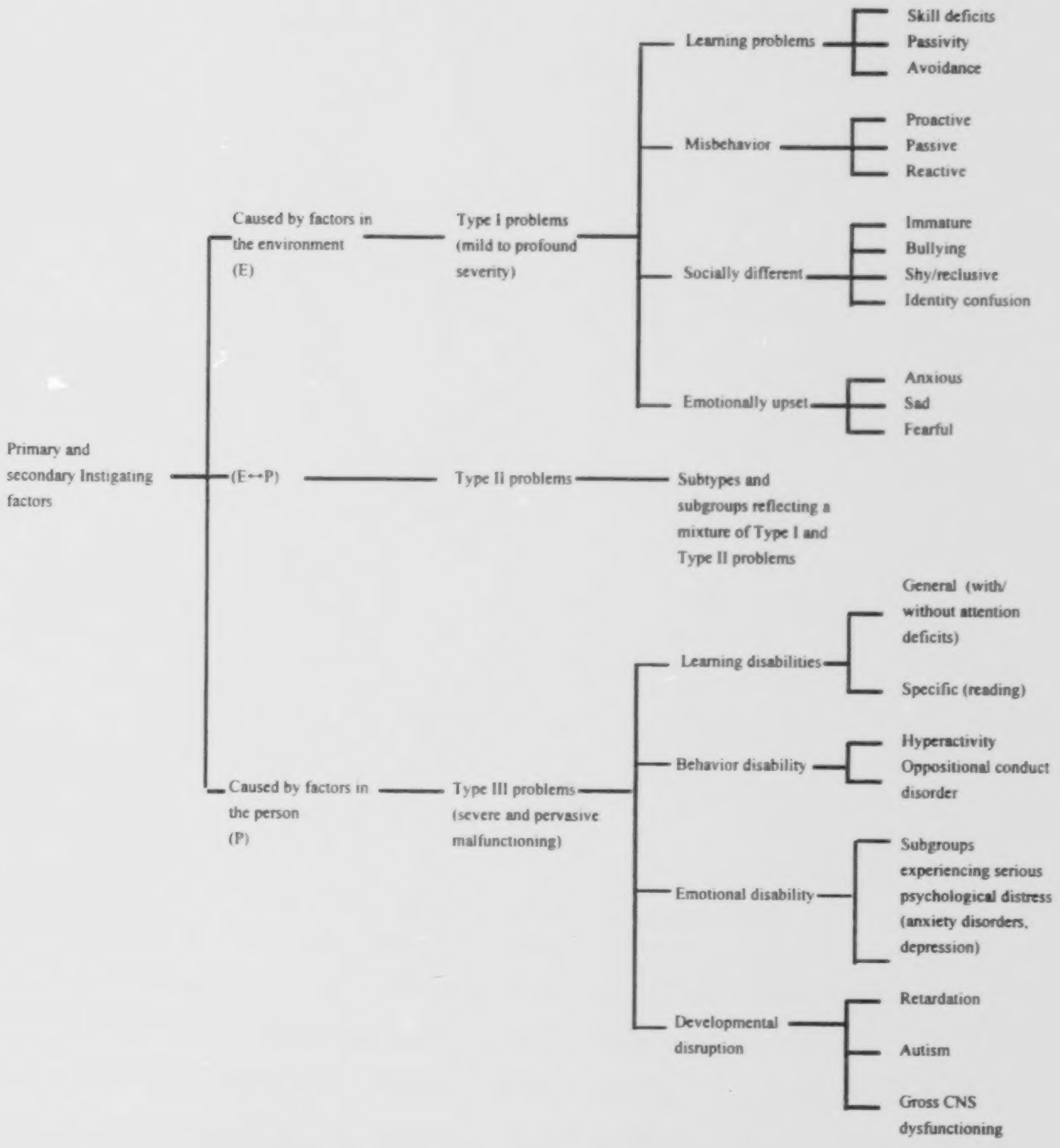
Figure 2: Categorization of Type I, II, and III Problems


Primary and secondary Instigating factors
Caused by factors in the environment (E)
(E↔P)
Caused by factors in the person (P)
Type I problems (mild to profound severity)
Type II problems
Type III problems (severe and pervasive malfunctioning)
Learning problems
Skill deficits
Passivity
Avoidance
Misbehavior
Proactive
Passive
Reactive
Socially different
Immature
Bullying
Shy/reclusive
Identity confusion
Emotionally upset
Anxious
Sad
Fearful
Subtypes and subgroups reflecting a mixture of Type I and Type II problems
Learning disabilities
General (with/without attention deficits)
Specific (reading)
Behavior disability
Hyperactivity
Oppositional conduct disorder
Emotional disability
Subgroups experiencing serious psychological distress (anxiety disorders, depression)
Developmental disruption
Retardation
Autism
Gross CNS dysfunctioning

Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

- **Challenges to Primary Support Group**
  - Challenges to Attachment Relationship
  - Death of a Parent or Other Family Member
  - Marital Discord
  - Divorce
  - Domestic Violence
  - Other Family Relatonship Problems
  - Parent-Child Separation
- **Changes in Caregiving**
  - Foster Care/Adoption/Institutional Care
  - Substance-Abusing Parents
  - Physical Abuse
  - Sexual Abuse
  - Quality of Nurture Problem
  - Neglect
  - Mental Disorder of Parent
  - Physical Illness of Parent
  - Physical Illness of Sibling
  - Mental or Behavioral disorder of Sibling
- **Other Functional Change in Family**
  - Addition of Sibling
  - Change in Parental Caregiver
- **Community of Social Challenges**
  - Acculturation
  - Social Discrimination and/or Family Isolation
- **Educational Challenges**
  - Illiteracy of Parent
  - Inadequate School Facilities
  - Discord with Peers/Teachers
- **Parent or Adolescent Occupational Challenges**
  - Unemployment
  - Loss of Job
  - Adverse Effect of Work Environment
- **Housing Challenges**
  - Homelessness
  - Inadequate Housing
  - Unsafe Neighborhood
  - Dislocation
- **Economic Challenges**
  - Poverty
  - Inadequate Financial Status
- **Legal System or Crime Problems**
- **Other Environmental Situations**
  - Natural Disaster
  - Witness of Violence
- **Health-Related Situations**
  - Chronic Health Conditions
  - Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Change in crying
- Change in mood
- Sullen, withdrawn

Impulsive/Hyperactive or Inattentive Behaviors
- Increased activity

Negative/Antisocial Behaviors
- Aversive behaviors, i.e., temper tantrum, angry outburst

Feeding, Eating, Elimination Behaviors
- Change in eating
- Self-induced vomiting
- Nonspecific diarrhea, vomiting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments
- Inability to engage in or sustain play

Sexual Behaviors
- Arousal behaviors

Relationship Behaviors
- Extreme distress with separation
- Absence of distress with separation
- Indiscriminate social interactions
- Excessive clinging
- Gaze avoidance, hypervigilant gaze...

EARLY CHILDHOOD (3-5Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Generally sad
- Self-destructive behaviors

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level

Negative/Antisocial Behaviors
- Tantrums
- Negativism
- Aggression
- Uncontrolled, noncompliant

Feeding, Eating, Elimination Behaviors
- Change in eating
- Fecal soiling
- Bedwetting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Ambivalence toward independence
- Socially withdrawn, isolated
- Excessive clinging
- Separation fears
- Fear of being alone

MIDDLE CHILDHOOD (6-12Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Anxiety
- Changes in mood
- Preoccupation with stressful situations
- Self -destructive
- Fear of specific situations
- Decreased self-esteem

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level
- Impulsivity

Negative/Antisocial Behaviors
- Aggression
- Noncompliant
- Negativistic

Feeding, Eating, Elimination Behaviors
- Change in eating
- Transient enuresis, encopresis

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Decrease in academic performance

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- Change in social interaction such as withdrawal
- Separation fear
- Fear of being alone

Substance Use/Abuse...

ADOLESCENCE (13-21Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Self-destructive
- Anxiety
- Preoccupation with stress
- Decreased self-esteem
- Change in mood

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- Impulsivity
- High activity level

Negative/Antisocial Behaviors
- Aggression
- Antisocial behavior

Feeding, Eating, Elimination Behaviors
- Change in appetite
- Inadequate eating habits

Somatic and Sleep Behaviors
- Inadequate sleeping habits
- Oversleeping

Developmental Competency
- Decrease in academic achievement

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- School absences
- Change in social interaction such as withdrawal

Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

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II. A FULL RANGE OF PROGRAMS TO ADDRESS BEHAVIORAL, EMOTIONAL, AND LEARNING PROBLEMS

*A*melioration of the full continuum of problems, requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that inter-ventions should be coordinated and, if feasible, integrated.

A. A Continuum of Community-School Programs: Primary Prevention through Treatment

To illustrate the comprehensive range of programs needed, a continuum is outlined on the following page. The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention -- through those for addressing problems soon after onset -- on to treatments for severe and chronic problems. With respect to *comprehensiveness*, the range of programs highlights that many problems must be addressed developmentally and with a range of programs --some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent inter-program linkages and for linkages over extended periods of time.

When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the helping strategies used primarily are some form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other.

Caution:

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs

Intervention Continuum

Examples of Focus and Types of Intervention

(Programs and services aimed at system changes and individual needs)

Primary prevention

1. *Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness*
   - economic enhancement of those living in poverty (e.g., work/welfare programs)
   - safety (e.g., instruction, regulations, lead abatement programs)
   - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
2. *Preschool-age support and assistance to enhance health and psychosocial development*
   - systems' enhancement through multidisciplinary team work, consultation, and staff development
   - education and social support for parents of preschoolers
   - quality day care
   - quality early education
   - appropriate screening and amelioration of physical and mental health and psychosocial problems

Early-after-onset intervention

3. *Early-schooling targeted interventions*
   - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
   - support and guidance to ameliorate school adjustment problems
   - personalized instruction in the primary grades
   - additional support to address specific learning problems
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
4. *Improvement and augmentation of ongoing regular support*
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - preparation and support for school and life transitions
   - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
   - parent involvement in problem solving
   - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
   - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
   - Academic guidance and assistance
   - Emergency and crisis prevention and response mechanisms
5. *Other interventions prior to referral for intensive, ongoing targeted treatments*
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

Treatment for severe/chronic problems

6. *Intensive treatments*
   - referral, triage, placement guidance and assistance, case management, and resource coordination
   - family preservation programs and services
   - special education and rehabilitation
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

Meeting the Needs of All Students

Providing a

CONTINUUM OF SCHOOL AND COMMUNITY PROGRAMS & SERVICES

Ensuring use of the

LEAST INTERVENTION NEEDED

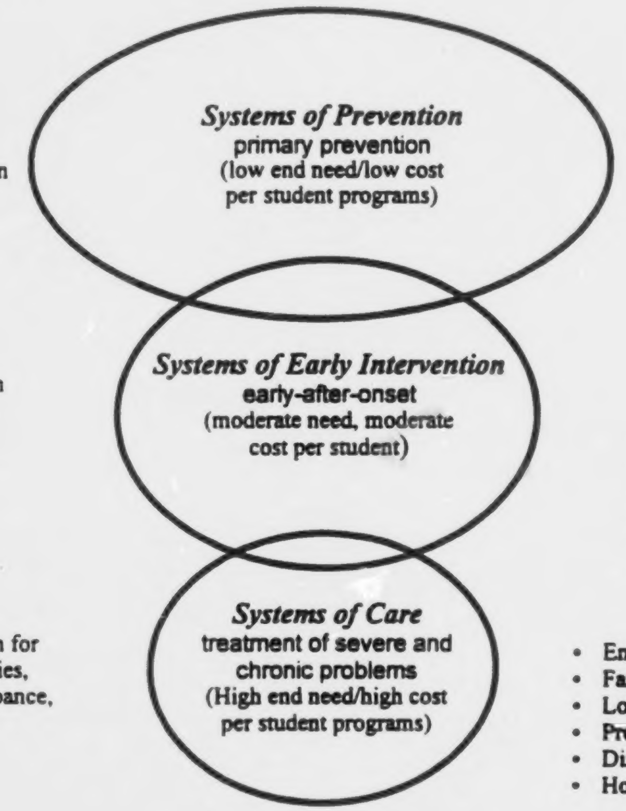
School **Resources**
(facilities, stakeholders, programs, services)

Examples:

- General health education
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement

- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs

- Special education for learning disabilities, emotional disturbance, and other health impairments



Systems of Prevention
primary prevention
(low end need/low cost per student programs)

Systems of Early Intervention
early-after-onset
(moderate need, moderate cost per student)

Systems of Care
treatment of severe and chronic problems
(High end need/high cost per student programs)

Community **Resources**
(facilities, stakeholders, programs, services)

Examples:

- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization

Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care.*

*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies;
(b) with jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters or schools)

B. Accommodations to Reduce Problems

It is easy to fall into the trap of thinking that corrective interventions for problems always should be directed at a specific individual. Adopting an interactional view, however, points to an expanded set of options regarding who or what should be the object of change (see Figure).

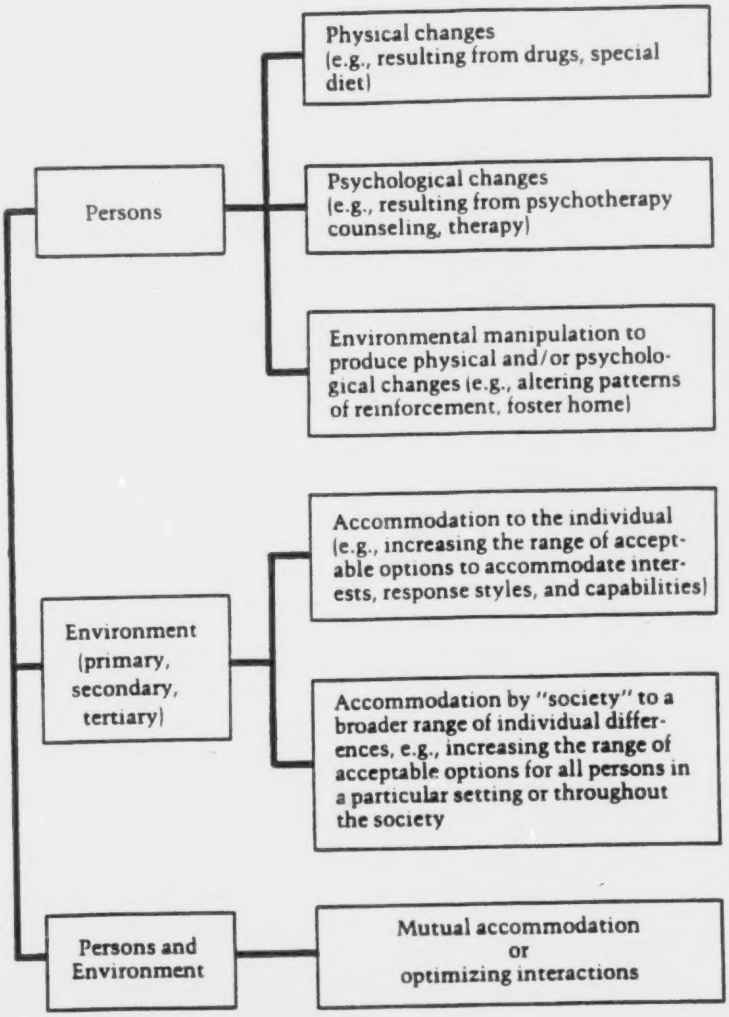
Currently, when a person is identified as having problems, efforts are made, directly or indirectly, to produce changes in the individual. Direct efforts include remediation, psychotherapy, and medically-related approaches. Indirect efforts include changing the way parents and teachers interact with youngsters.

Interventions designed to change the individual may be the most appropriate choice in any given case. Sometimes, however, the environment needs to change in ways that attempt to accommodate rather than modify individual differences. Such environmental changes are not the same as modifying the environment as an indirect way of changing the individual.

Instructing parents and teachers to be more discriminating in their use of reinforcement contingencies is meant to be an indirect way of changing the child. It is not a strategy for teaching parents and teachers the value of offering additional options whenever appro-priate and feasible -- such as increasing the range of choices about what a child is allowed to do and how the child is allowed to pursue a chosen option. It also is not the same as helping them and others in the society to understand the impact of appropriately changing their expectations about what is acceptable behavior, performance, and progress.

The implications of an expanded focal point for intervention are immense. For one, environments and the interactions between persons and environments become primary concerns for assessment activity and corrective interventions. Problem prevention efforts expand to include programs that encourage accommodation of a wider range of individual differences in schools and society. And the broadened perspective works against presumptions about dysfunctions within people as the source of most problems.

Options Related to Focal Point of Intervention
(Who or what is to be the object of change?)


Persons
Physical changes (e.g., resulting from drugs, special diet)
Psychological changes (e.g., resulting from psychotherapy counseling, therapy)
Environmental manipulation to produce physical and/or psychological changes (e.g., altering patterns of reinforcement, foster home)
Environment (primary, secondary, tertiary)
Accommodation to the individual (e.g., increasing the range of acceptable options to accommodate interests, response styles, and capabilities)
Accommodation by "society" to a broader range of individual differences, e.g., increasing the range of acceptable options for all persons in a particular setting or throughout the society
Persons and Environment
Mutual accommodation or optimizing interactions

Accommodations for Individuals with Disabilities is More than a Good Idea–it's the Law

From an article by Michael Perla, Ed. S., NCSP, Cobb County (GA) Public Schools

Section 504

An Introduction for Parents

Background

Section 504 is part of the Rehabilitation Act of 1973, and applies to all institutions receiving federal financial assistance, such as public schools. The law essentially places an obligation on public schools to provide a "free appropriate public education" to children with disabilities, along with related services such as transportation and counseling. The main purpose of 504 is to prohibit discrimination while assuring that disabled students have educational opportunities and benefits equal to those provided to non-disabled students. The Office of Civil Rights (OCR) monitors compliance under 504. Unlike special education laws, Section 504 does not provide financial support to schools.

A student is considered to be handicapped under 504 if he or she (1) has a physical or mental impairment that substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Limiting a major life activity is an important part of this definition and includes handicaps that limit taking care of oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing or learning. The last example, learning, is the one frequently considered in 504 cases in the schools. Section 504 requires school districts to offer services to some children who might not qualify for special education benefits under the Individuals with Disabilities Education Act of 1990 (IDEA; this federal act funds special education services). For example, children who have AIDS, asthma and diabetes may all be covered under Section 504.

Eligibility/Assessment/Accommodations Under 504

Schools must notify parents of their rights regarding identification, evaluation and placement of children with suspected handicaps prior to starting a Section 504 evaluation. In addition, students who are not found eligible under IDEA should be considered for possible eligibility under Section 504. In a 504 referral, the school often tries to determine: (1) Does the student have a physical or mental impairment? (2) Does the impairment affect one of the major life activities? If the answers to these questions are yes, the student may be entitled to a Section 504 accommodation plan. Accommodations must be based on a child's educational needs and may include curricular, classroom, school and grading modifications.

Section 504 requires school districts to develop detailed procedures for identifying and serving children with disabilities. Like other special education laws, 504 requires schools to conduct activities that will help locate and identify children who have disabilities and are not currently receiving needed special services.

Parental Rights and Procedures Under 504

Referral: Parents, guardians or school personnel may refer students suspected of having a handicap to the Section 504 coordinator or similar personnel. Potential candidates for 504 services include children with cancer, communicable diseases, medical conditions and Attention Deficit Hyperactivity Disorder...

Services under 504: If a child is found eligible under 504, services are primarily provided in the regular education classroom. The types of services offered might include the use of behavioral management techniques (e.g., a token economy), adjusting class schedules, mollifying tests and tailoring homework assignments.

Home-school collaboration: Parents can help increase the likelihood that 504 plans are effective by working closely with general educators and other school personnel to implement intervention programs both at school and at home. Regular parent-teacher conferences are likely to help foster this relationship.

Resources for Parents

Rothstein, L.F. (1995). *Special education law (2nd ed.).* New York: Longman Publishers.

Zirkel, P.A. (1993). *Section 504 and the schools.* Horsham. PA: LRP Publications

Ideas into Practice

Asking for Accommodations

Primary health care providers, parents, and others who identify youngsters experiencing behavior, emotional, and learning problems need to know about Section 504 of the 1973 Rehabilitation Act.

Section 504 is anti-discrimination, civil rights legislation (not a grant program). It provides a basis to seek accommodations at school not only for students who are eligible under the Individuals with Disabilities Education Act (IDEA) but for any who are identified as having some physical or mental impairment that affects a major life activity, such as learning at school. Accommodations to meet educational needs may focus on the curriculum, classroom and homework assignments, testing, grading, and so forth. Such accommodations are primarily offered in regular classrooms.

Below is a fact sheet developed by folks in New Mexico to provide a quick overview. (Thanks to Steve Adelsheim for sharing it!)

General Purpose

Section 504 is a broad civil rights law which protects the rights of individuals with "disabilities" in programs and activities that receive federal financial assistance from the U.S. Department of Education.

Who is protected?

Section 504 protects all school-age children who qualify as disabled, i.e., (1) has or (2) has had a physical or mental impairment which substantially limits a major life activity or (3) is regarded as disabled by others. Major life activities include walking, seeing, breathing, teaming, working, caring for oneself and performing manual tasks. The disabling condition need only limit one major life activity in order for the student to be eligible. Children receiving special education services under the Individual's with Disabilities Act (IDEA) are also protected by Section 504.

Examples of potential 504 disabling conditions not typically covered under IDEA are:

*communicable diseases
*Tuberculosis
*HIV/AIDS
*medical condition (asthma, allergies, diabetes, heart disease)
*temporary conditions due to illness or accident
*Attention Deficit Hyperactivity Disorder
*behavioral difficulties
*drug/alcohol addiction (if the student is no longer using drugs/alcohol)

A 504 plan provides:

*an evaluation based on current levels of performance, teacher reports, and documentation of areas of concern
*the development/implementation of an accommodation plan which specifies "reasonable" modifications in order for the student to benefit from his/her educational program;
*procedural safeguards for students and parents including written notification of all District decisions concerning the student's evaluation or educational placement and due process:
*review and re-evaluation of modifications and placement on a regular basis and prior to any change in placement.

A 504 plan should be considered when:

*a student shows a pattern of not benefiting from the instruction being provided
*retention is being considered
*a student returns to school after a serious illness or injury
*long-tem suspension or expulsion is being considered
*a student is evaluated and found not eligible for Special Education services or is transitioning out of Special Education
*a student exhibits a chronic health or mental health condition
*substance abuse is an issue
*when a student is "at risk" for dropping out
*when a student is taking medication at school

For more information, contact your local school administration.

Also see L. Miller & C. Newbill (1998). *Section 504 in the classroom: How to design & implement accommodation plans.* Austin, TX: pro.ed.

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Broadening the Concept of Cultural Competence

Because many young people experience biases and prejudices associated with one or more "cultural differences," the *Family and Youth Services Bureau** has taken pains to define cultural diversity. An African American lesbian, for example, is tied to, and some-times torn between, communities of color, gender, and sexual orientation, and may have experienced different forms of racist, sexist, and homophobic attitudes in each. The following expanded definitions, therefore, are meant to foster appreciation of the need to develop cultural competence. Each factor, of course, must be considered in the context of individual experience.

- **Ethnic/Racial Background:** Any of the different varieties or populations of human beings distinguished by physical traits, blood types, genetic code patterns, or inherited characteristics unique to an isolated breeding population. People from different racial backgrounds have diverse perspectives, customs and social upbringing. Because of the historically dominant nature of a majority culture, most people have little exposure to different racial cultures.
- **Gender Culturalization**: Societal influences, messages, or "training" to behave in a certain ways based on one's gender. The majority culture in most parts of the world is the patriarchy, where male 'qualities' are more valued and men are provided access to greater opportunity. Thus, in very insidious ways, young girls and boys are acculturated differently, which affects their sense of self-worth and ability to fulfill their potential.
- **Socioeconomic/Educational Status:** Involving both social and economic factors and/or access to educational opportunities. A person's socioeconomic status can be a major factor in development as it relates to access to opportunity, social status, the ability to meet primary survival needs (food, clothing, shelter), and the messages received about what can be hoped for and attained. Closely related to socioeconomic status is access to educational opportunities that result in exposure to new ideas, the ability to think critically, and a willingness to consider different points of view.
- **Sexual Orientation:** A person's interest in, or innate desire to, develop emotional and physical relationships that are heterosexual, homosexual, or bisexual. The majority culture sanctions heterosexual behavior as the norm. Homosexuals and bisexuals, therefore, have been forced to keep their sexual orientation private, often out of fear, and those struggling with gender identity issues face similar isolation. Homo-phobia remains a public acceptable discrimination.
- **Physical Capacity:** The ability to function or perform tasks based on one's physical capabilities or limit-ations. The majority culture has until recently created systems and structures primarily suited for those with full physical capacity, and has devalued people without such capacity. Passage of the Americans with Disabilities Act now requires local organizations to modify systems and structures to provide broader access to persons with disabilities.
- **Age/Generational:** The distinct phases of human development, both innate and socialized; the beliefs/attitudes/values of persons born during the same period of time. Each generation has its own distinct culture, and values, based on the time they were born, lived as children, and transitioned to adulthood. The division between youth, adults, and the elderly has become more pronounced due to family relocations and breakdowns in intergenerational activities.
- **Personality Type:** The patterns and qualities of personal behavior as expressed by physical, emotional, or intellectual activities or responses to situations and people. People have innate personality types that affect their interaction with others. Extroverts, for example, may be more comfortable in large group settings, while introverts, who can adapt to such settings, may draw strength from their private time. While personality type is affected by age, experience, and circumstance, key personality-related preferences and styles remain with most people throughout their lifetime.
- **Spirituality/Religious Beliefs:** Of the spirit or soul as distinguished from material matters; characterized by the adherence to a religion and its tenets or doctrines. There are numerous religions, both formal and informal, that guide people's lives. Each has its own distinct traditions and belief systems. Further, while some people do not belong to an organized religion, they believe in spiritual feelings and the connectedness between people with certain values.
- **Regional Perspectives:** The words, customs, etc., particular to a specific region of a country or the world. Each corner of the world, and even the regions within a country, has traditions, rites of passage, learning experiences, and customs that are unique. Working with people requires an understanding of the special perspectives/life experiences they acquired growing up in different parts of the world.
- **New Immigrant Socialization:** The adaptation process of those recently relocated to a new environment. Relocating to a new country or region of the world requires adapting to new sights, sounds, and customs. This process is typically different for each generation of a family, with young people often adapting more quickly to the new culture. These differential adaptation patterns can affect the family unit as much as the change in culture itself.

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*Adapted from *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs* (1994). USDHHS, Admin. for Children and Families, Admin. on Children, Youth, and Families, Families & Youth Services Bureau. Washington, DC.

For more on this topic, see the Center's Introductory Packet entitled: *Cultural Concerns in Addressing Barriers to Learning.*

communities together

FACT SHEET

Cultural Competence in Serving Children and Adolescents With Mental Health Problems

All cultures practice traditions that support and value their children and prepare them for living in their society. This way, cultures are preserved for future generations.

Culturally competent mental health service providers and the agencies that employ them are specially trained in specific behaviors, attitudes, and policies that recognize, respect, and value the uniqueness of individuals and groups whose cultures are different from those associated with mainstream America. These populations are frequently identified as being made up of people of color—such as Americans of African, Hispanic, Asian, and Native American descent. Nevertheless, cultural competence as a service delivery approach can be applied to systems that serve all persons, because everyone in the society has a culture and is part of several subcultures, including those related to gender, age, income level, geographic region, neighborhood, sexual orientation, religion, and physical disability.

Culturally competent service providers are aware and respectful of the importance of the values, beliefs, traditions, customs, and parenting styles of the people they serve. They are also aware of the impact of their own culture on the therapeutic relationship and take all of these factors into account when planning and delivering services for children and adolescents with mental health problems and their families.

In a "System of Care," local organizations work in teams–with families as critical partners–to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

Goals and Principles of Cultural Competence

Culturally competent "systems of care" provide appropriate services to children and families of all cultures. Designed to respect the uniqueness of cultural influences, these systems work best within a family's cultural framework. Nine principles govern the development of culturally competent programs:

1. The family, however defined, is the consumer and usually the focus of treatment and services.
2. Americans with diverse racial/ethnic backgrounds are often bicultural or multicultural. As a result, they may have a unique set of mental health issues that must be recognized and addressed.
3. Families make choices based on their cultural backgrounds. Service providers must respect and build upon their own cultural knowledge as well as the families' strengths.
4. Cross-cultural relationships between providers and consumers may include major differences in world views. These differences must be acknowledged and addressed.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301.443.2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1.800.789.2647 • FAX 301.984.8796
TTY 301.443.9006 • CMHS Electronic Bulletin Board 1.800.790.2647

SAMHSA

5. Cultural knowledge and sensitivity must be incorporated into program policymaking, administration, and services.
6. Natural helping networks such as neighborhood organizations, community leaders, and natural healers can be a vital source of support to consumers. These support systems should be respected and, when appropriate, included in the treatment plan.
7. In culturally competent systems of care, the community, as well as the family, determine direction and goals.
8. Programs must do more than offer equal, nondiscriminatory services; they must tailor services to their consumer populations.
9. When boards and programs include staff who share the cultural background of their consumers, the programs tend to be more effective.

Ideally, culturally competent programs include multilingual, multicultural staff and involve community outreach. Types of services should be culturally appropriate; for example, extended family members may be involved in service approaches, when appropriate. Programs may display culturally relevant artwork and magazines to show respect and increase consumer comfort with services. Office hours should not conflict with holidays or work schedules of the consumers.

Developing Cultural Competence

Although some service providers are making progress toward cultural competence, much more needs to be done. Increased opportunities must be provided for ongoing staff development and for employing multicultural staffs. Improved culturally valid assessment tools are needed. More research will be useful in determining the effectiveness of programs that serve children and families from a variety of cultural backgrounds.

For many programs, cultural competence represents a new way of thinking about the philosophy, content, and delivery of mental health services. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice. Even the concept of a mental disorder may reflect a western culture medical model.

At the Policymaking Level

Programs that are culturally competent:

- appoint board members from the community so that voices from all groups of people within the community participate in decisions;
- actively recruit multiethnic and multiracial staff;
- provide ongoing staff training and support developing cultural competence;
- develop, mandate, and promote standards for culturally competent services;
- insist on evidence of cultural competence when contracting for services;
- nurture and support new community-based multicultural programs and engage in or support research on cultural competence;
- support the inclusion of cultural competence on provider licensure and certification examinations; and
- support the development of culturally appropriate assessment instruments, for psychological tests, and interview guides.

At the Administrative Level

Culturally competent administrators:

- include cultural competency requirements in staff job descriptions and discuss the importance of cultural awareness and competency with potential employees;
- ensure that all staff participate in regular, inservice cultural competency training;
- promote programs that respect and incorporate cultural differences; and
- consider whether the facility's location, hours, and staffing are accessible and whether its physical appearance is respectful of different cultural groups.

At the Service Level

Practitioners who are culturally competent:

- learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences;
- include neighborhood and community outreach efforts and involve community cultural leaders if possible;
- work within each person's family structure, which may include grandparents, other relatives, and friends;
- recognize, accept, and, when appropriate, incorporate the role of natural helpers (such as shamans or curanderos);
- understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact with a person; or access to a family may be gained only through an elder);
- know that, for many people, additional tangible services—such as assistance in obtaining housing, clothing, and transportation or resolving a problem with a child's school—are expected, and work with other community agencies to make sure these services are provided;
- adhere to traditions relating to gender and age that may play a part in certain cultures (for example, in many racial and ethnic groups, elders are highly respected). With an awareness of how different groups show respect, providers can properly interpret the various ways people communicate.

Achieving Cultural Competence

To become culturally competent, programs may need to:

- assess their current level of cultural competence;
- develop support for change throughout the organization and community;
- identify the leadership and resources needed to change;
- devise a comprehensive cultural competence plan with specific action steps and deadlines for achievement; and
- commit to an ongoing evaluation of progress and a willingness to respond to change.

Important Messages About Children's and Adolescents' Mental Health:

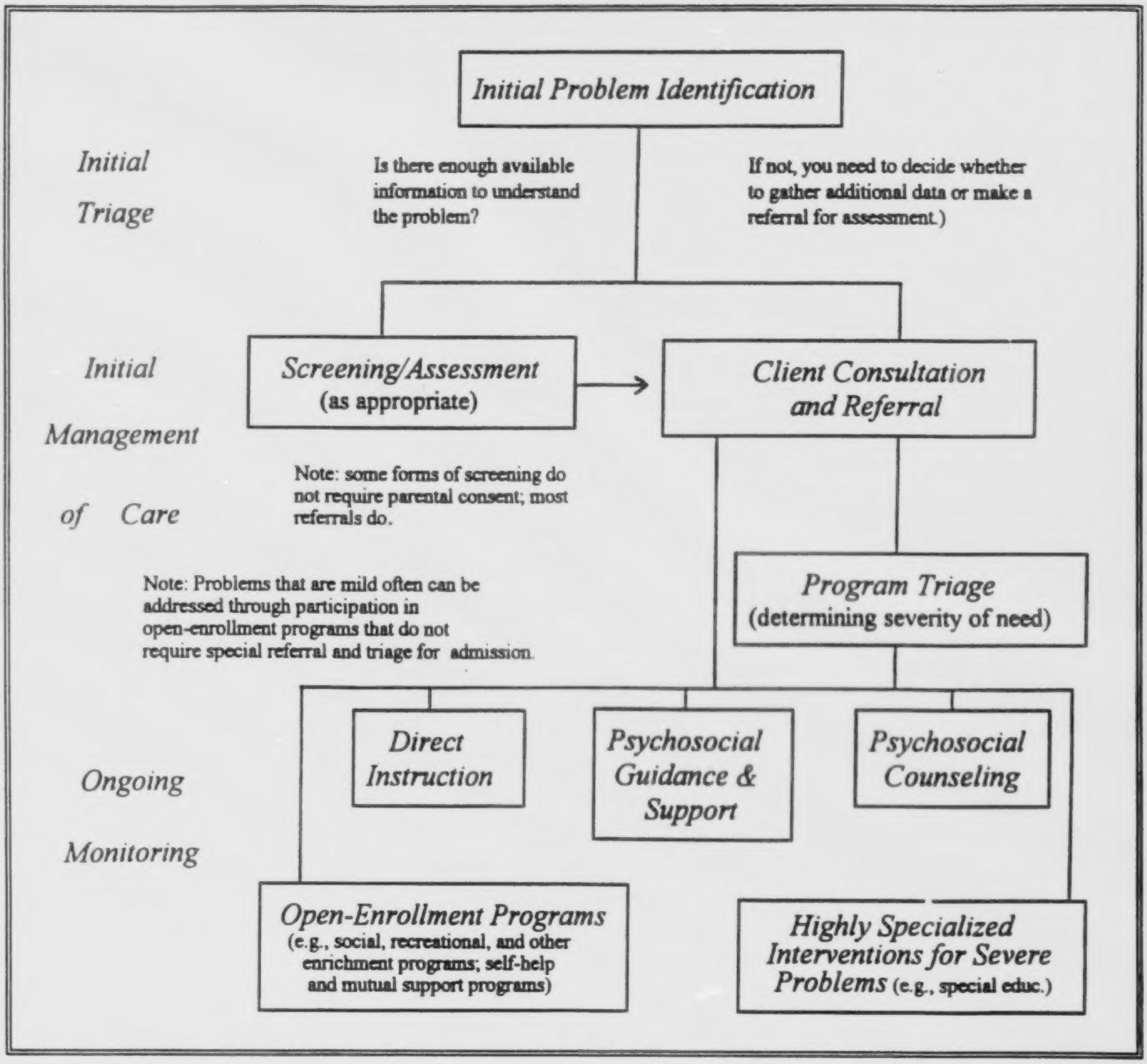
- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1.800.789.2647.

This fact sheet is based on a monograph, *Towards a Culturally Competent System of Care*, authored by Terry L. Cross, Karl W. Dennis, Mareasa R. Isaacs, and Barbara J. Bazron, under the auspices of the National Technical Assistance Center for Children's Mental Health at Georgetown University in Washington, D.C., and funded by the National Institute of Mental Health (1989).

For free information about children's and adolescents' mental health—including publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006.

C. Developing Systems at a School for Problem Identification, Triage, Referral and Management of Care

In responding to the mental health and psychosocial concerns of students, school staff make a variety of decisions. This figure and the outline on the following page highlight matters to be considered as a school develops its systems for problem identification, triage, referral and management of care.


Initial Problem Identification
Initial Triage
Is there enough available information to understand the problem?
If not, you need to decide whether to gather additional data or make a referral for assessment.)
Initial Management of Care
Screening/Assessment (as appropriate)
Client Consultation and Referral
Note: some forms of screening do not require parental consent; most referrals do.
Note: Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.
Program Triage (determining severity of need)
Ongoing Monitoring
Direct Instruction
Psychosocial Guidance & Support
Psychosocial Counseling
Open-Enrollment Programs (e.g., social, recreational, and other enrichment programs; self-help and mutual support programs)
Highly Specialized Interventions for Severe Problems (e.g., special educ.)

The following outline highlights matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

Problem identification

(a) Problems may be identified by anyone (staff, parent, student).
(b) There should be an Identification Form that anyone can access and fill out.
(c) There must be an easily accessible place for people to turn in forms.
(d) All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

Triage processing

(a) Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
(b) After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).

Clients directed to resources or for further problem analysis and recommendations

(a) For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
(b) If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
(c) The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex situations, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

Interventions to ensure recommendations and referrals are pursued appropriately

(a) In many instances, peripheral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
(c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

Management of care (case monitoring and management)

(a) Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.
(b) Other situations require intensive management by specially trained professionals to (1) ensure interventions are coordinated/integrated and appropriate, (2) continue problem analysis and determine whether appropriate progress is made, (3) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
(c) One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.

This material is from the Center's Technical Aid Packet entitled *School-based Client Consultation, Referral, and Management of Care* which discusses the importance of approaching student clients as consumers and to think in terms of managing *care* not *cases*. The packet also discusses pereferral interventions and deals with referral as a multifaceted intervention. Examples of tools to aid in these processes are included. See Section V for information on how to request this technical resource aid.

D. Treatments for Psychosocial Problems and Disorders

A continuum of interventions for addressing psychosocial problems was presented at the beginning of section II. It is easy to conceptualize a comprehensive set of interventions. It is excruciatingly hard to (1) establish such a range of programs, (2) integrate those that are in operation, and (3) conduct the type of research that advances understanding.

Given the difficulty in establishing comprehensive, integrated programmatic efforts, it is not surprising that research on this topic is almost nonexistent. Physical and mental health programs, for example, rarely are coordinated with each other or with social service, educational, and vocational programs, and thus illustrate the problem of piecemeal and fragmented intervention.

For the most part, programs for each type of problem are developed and function separately. An individual identified as having several problems may be involved in counseling with several professionals working independently of each other.

Deficiencies related to comprehensiveness and interface are attributable in significant measure to the way interventions are conceived and organized and the way professionals understand their roles and functions. Most practitioners and intervention researchers spend the majority of their time working directly with specific interventions and samples and give little thought or time to comprehensive models of mechanisms for program development and collaboration.

There is agreement in making general decisions about intervening for problems that activity should be kept to the necessary minimum. For example, if an individual with emotional problems can be helped effectively at a community agency, this seems better than placing the person in a mental hospital. For special education populations, when a student with learning or behavior problems can be worked with effectively in a regular classroom, placement in a special education program is inappropriate. There is strong disagreement, however, in treatment orientations. Should one focus on underlying factors, on observable behaviors, or both?

The *underlying factors* orientation is based on the assumption that many problems in functioning are symptoms of an underlying problem. As outlined in the Table, practitioners adopting this orientation hypothesize and attempt to address motivational and developmental differences.

The roots of the orientation are found in medical, psycho-therapeutic, and educational concepts. For instance, emotional distress is identified as underlying a behavior problem. In turn, the emotional distress is seen as psychologically based.

Corrective interventions emerging from the underlying factors orientation usually are built on assessments designed to analyze areas such as perceptual, motor, cognitive, language, social, and emotional functioning. In addition, psychoneurological or neurological testing may be done to aid diagnosis. Intervention strategies draw on psycho-therapeutic principles. Examples are application of broad-based psychodynamic principles, use of social interaction and modeling, rapport building to reduce anxiety and increase positive involvement, and so forth. When underlying factors appear resistant to treatment, interveners teach individuals ways to compensate for their problems. And although the primary overall concern is with underlying factors, intervention rationales may also designate provision of support for ongoing growth and learning.

In contrast, interveners adopting an *observable factors orientation* see no value in assumptions about underlying factors. Instead, individuals with problems are seen as not yet having learned necessary skills or as having acquired interfering behaviors.

The conceptual roots of the observable factors orientation are in behaviorism (operant and cognitive behavior modification). Proponents of this approach assess knowledge and skills directly associated with daily life tasks. Performance below prevailing standards for an individual's level of development is seen as indicating missing capabilities. Behavioral objectives are formulated to teach these missing capabilities and to address any interfering behaviors. Direct intervention approaches are stressed, such as eliciting and reinforcing specific responses and instruction in cognitive self-direction and monitoring. That is, corrective strategies emphasize direct and system-atic teaching and behavior management drawing on behavior change principles.

Because neither orientation is sufficiently effective over the long run, proponents in each camp have looked to contemporary cognitive concepts and methods in evolving their approaches. Essentially, they have incorporated instruction of efficient strategies for planning, self-direction, remembering, self-monitoring, problem solving, and so forth. Currently, *metacognitive strategies* are widely used in both camps. Proponents of the two prevailing orientations adapt such strategies to fit in with their own views. That is, those with an underlying factors orientation view metacognitive strategies as an underlying ability or as a way for an individual to compensate for an area of dysfunction. Advocates of observable factors see metacognitive strategies as another set of skills clients should acquire through direct instruction.

Treatment and remedial approaches in psychology and education have been described extensively in books and journals. One reads about counseling, behavior modification, psychodynamic therapy, remedial techniques, rehabilitation, metacognitive strategies, and so forth.

Table: Contrasting Orientations to Treatment and Remediation

	UNDERLYING FACTORS ORIENTATION	**OBSERVABLE FACTORS ORIENTATION**
PRIMARY OVERALL CONCERN	Motivational and developmental differences and disabilities that disrupt desired functioning	Unlearned skills and interfering behavior
	Specific Areas of Concern ***Motivation*** • reactive motivation problems • proactive motivation problems ***Development*** • perceptual problems • motor problems • cognitive problems • language problems • social problems • emotional problems *Knowledge, skills, and attitudes to compensate for disabilities*	**Specific Areas of Concern** Knowledge and skills relevant for performing life tasks • readiness needs Contemporary task needs • general life adjustment needs
SECONDARY CONCERNS	Enhancing intrinsic motivation knowledge and skills relevant for performing life tasks	Interfering behaviors (e g. poor impulse control, lack of sustained attention)
TERTIARY CONCERNS	Interfering behaviors	
PROCESS COMPONENTS	**Assessment** Construct-oriented assessment of developmental and motivational functioning as a basis for program planning and evaluation	**Assessment** Task-based assessment of knowledge and sequential skills as a basis for program planning and evaluation
	Form of Objectives Nonbehavioral, as well as behavioral and criterion-referenced objectives	**Form of Objectives** Behavioral and criterion-referenced objectives
	Treatment/Remedial Rationale and Methods Therapeutic-oriented interventions (primary emphasis on establishing rapport through interpersonal dynamics and use of a variety of intervention models) • counseling and psychotherapy • expanded life task options and choices • minimized coercion • enhanced interpersonal option • accommodation of a wide range of motivational and developmental differences • exercises intended to correct developmental anomalies and accelerate lagging development • eclectic instruction related to compensatory strategies • eclectic strategies for reducing interfering behaviors	**Treatment/Remedial Rationale and Methods** Behavior change interventions (primary emphasis on establishing control over behavior through manipulation of reinforcers and use of cognitive self-direction and monitoring) • direct instruction to teach missing skills and information • behavior management to reduce interfering behaviors

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The following is the lead article from the UCLA Center for Mental Health in School's Fall, 1998 *Addressing Barriers to Learning* Newsletter.

And so the pendulum swings back. "No more social promotion!" "Stop passing on failure!" O.K., but let's act quickly to minimize the social and mental health fallout.

Denying Social Promotion Obligates Schools to Do More to Address Barriers to Learning

Everyone understands the downside of social promotion. Why then did social promotion become de facto policy in so many schools? Because the alternative often is grade retention, and everyone knows the slippery slope that produces. As John Holt (1964) cautioned long ago, if we just focus on raising standards, we will see increasing numbers who can't pass the test to get into the next grade and the elementary and middle school classrooms will bulge and the "push out" rates will surge.

Even with widespread social promotion policies, retention is rampant. A recent American Federation of Teachers' report estimates that between 15 and 19 percent of the nation's students are held back each year and as many as 50% of those in large urban schools are held back at least once. With social promotion denied, estimates are that, for example, over 10,000 public school students in Chicago face retention, and over 70,000 in North Carolina could be retained for failing to meet promotion guidelines.

Last January, an newspaper editorial cautioned:

> *. . . we don't know yet how many students will be able to meet the higher expectations California is in the process of getting set for them. Some educators have guessed that more than half of the state's 5 million public school students will fail the tests, but nobody can say for sure. And there is plenty of debate about when and for how long students should be held back. The state will need to weigh the considerable risk that some students, particularly in the upper grades, will drop out rather than repeat another year. Will there be room in the state's many already overcrowded schools to house millions of students for another year or more? With the teacher shortage already a problem, who will teach them?*
>
> (from the *Sacramento Bee*)

The editorial might also have noted that

- research has not found long-term benefits from simply retaining students -- that is most students do not catch up and those who make some gains tend to lag behind again as they move to higher grades
- when students are kept back, they exhibit considerable reactance -- displaying social and mental health problems, such as negative attitudes toward teachers and school, misbehavior, symptoms of anxiety and depression, and so forth
- most schools are ill-prepared to respond with enough proactive programs to meet the academic, social, and emotional needs of students who are not ready to move on.

What's Missing?

School reformers are among the leading advocates for ending social promotion. In its place, the prevailing wisdom is to enhance students' desire to do well at school by instituting higher standards, improving instruction, and insisting on greater accountability. For those who need something more, the focus is on adding learning supports, such as tutoring, counseling, and summer school.

The concern arises: *Will schools provide enough support?* All districts can list a variety of learning supports they offer. Some are spread throughout the district; others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, to those identified as "at risk," and/or to those in need of compensatory education. The activities may be implemented in regular or special education classrooms and may be geared to an entire class, groups, or individuals; or they may be designed as "pull out" programs for designated students.

On paper, it often seems like a lot. It is common knowledge, however, that few schools come close to having enough. Most offer only bare essentials. Too many schools can't even meet basic needs.

Schools in poor neighborhoods are encouraged to link with community agencies in an effort to expand access to assistance. The problem with this emphasis on school-linked services is that there simply are not enough public resources to go around. Thus, as more schools try to connect with community agencies, they find all available resources have been committed. Agencies then must decide whether to redeploy resources among many schools. In either case, school-linked service only expand availability to a few students and families.

Families who have the means can go to the private sector for help. Those who lack the means must rely on public policy. The sad fact is that existing policy only provides enough learning supports to meet the needs of a small proportion of students. Thus, a fundamental component is missing from the mix of interventions necessary for avoiding retention of an overwhelming mass of students. Without attending to this deficiency in public policy, pendulum swings back and forth between social promotion and retention practices are inevitable and simply amount to political responses to public outcries.

What Should Schools Do?

The basic question that must be answered is: What should schools be doing to enable *all* students to learn and *all* teachers to teach effectively? A satisfactory answer is one that ensures reforms do more than promote the interests of youngsters who already are connecting with instruction. Schools must also address the needs of those encountering barriers to learning.

Although some youngsters have disabilities, the majority of learning, behavior, and emotional problems seen in schools stem from situations where *external barriers* are not addressed. The litany of barriers is all too familiar to anyone who lives or works in communities where families struggle with low income. Families in such neighborhoods usually can't afford to provide the many basic opportunities (never mind enrichment activities) found in higher income communities. Furthermore, resources are inadequate for dealing with such threats to well-being and learning as gangs, violence, and drugs. In many instances, inadequate attention to language and cultural considerations and high rates of student mobility creates additional barriers not only to student learning but to efforts to involve families in youngsters' schooling. And, the impact of all this is exacerbated as youngsters internalize the frustrations of confronting barriers and the debilitating effects of performing poorly at school.

Along with raising standards, schools must move quickly to develop classroom and school-wide approaches to address barriers to learning and teaching. This means working with communities to build a continuum that includes (a) primary prevention and early-age programs, (b) early-after-onset interventions, and (c) treatments for severe and chronic problems. Such a continuum is meant to encompass programs to promote and maintain safety and physical and mental health, preschool and early school-adjustment programs, efforts to improve and augment ongoing social and academic supports, ways to intervene prior to referral for intensive treatment, and provisions for intensive treatment. Such activity must be woven into the fabric of every school. In addition, families of schools need to establish linkages in order to maximize use of limited school and community resources. Minimally, schools that eliminate social promotion must deal proactively with the eight concerns outlined on the next page.

Prevention – Eliminating the Need for Social Promotion or Retention

Eliminating the need for both social promotion and retention is certainly an area that requires the proverbial ounce of prevention. Better yet, given the pervasiveness of barriers to learning, we could use several pounds of the stuff. To these ends, there is much of relevance in any public health agenda.

From a school perspective, success is a function of what a student can and wants to do, what a teacher can and wants to do, and the context in which they meet together each day. With respect to the student part of the equation, enhancing school readiness is a top priority. Most parents with the means to do so ensure their children have a wide range of quality experiences prior to entering kindergarten. The sad fact is that the majority of students who do not meet standards for promotion come from economically impoverished families. Until the society is willing to assist all those families who cannot access essential readiness experiences, too many students will continue to appear at school unready for the challenges ahead.

Eight Key Concerns for Schools as They Eliminate Social Promotion

Prevention

*Promoting Prekindergarten Interventions

(e.g., home and community-oriented programs to foster healthy social-emotional-cognitive development; quality day care programs; quality Head Start and other preschool programs; health and human services)

*In-service for teachers

(Even given smaller classes in some grades, the need remains for school-based in-service programs so that teachers can enhance strategies for preventing and minimizing barriers to learning and promoting intrinsic motivation for learning at school. A key aspect involves enhancing daily on-the-job learning for teachers through strong mentoring and increased collegial teaming and assistance.)

*Support for Transitions

(e.g., school-wide approaches for welcoming, orienting, and providing social supports for new students and families; articulation programs; enhanced home involvement in problem solving; ESL classes for students and those caretakers in the home who need them)

*School-Wide Programs Designed to Enhance Caring and Supportive School Environments

(e.g., increasing curricular and extra-curricular enrichment and recreation programs; increasing the range of opportunities for students to assume positive roles)

Early-After-Onset Intervention

*Improving and Augmenting Regular Supports as Soon as a Student is Seen to Have a Problem

(e.g., personalizing instruction; tutoring; using aides and volunteers to enhance student support and direction; mentoring for regular teachers regarding basic strategies for enhancing student support, introducing appropriate accommodations and compensatory strategies, and remedying mild-moderate learning problems; extended-day, after-school, Saturday, and summer school programs)

*Interventions for Mild-Moderate Physical and Mental Health and Psychosocial Problems

(e.g., school-wide approaches and school-community partnerships to address these needs among the student body)

Provision for Severe and Chronic Problems

*Enhancing Availability and Access to Specialized Assistance for Persisting Problems

(e.g., school-based and linked student and family assistance interventions, including special education)

*Alternative Placements

With respect to the teacher part of the equation, enhancing teacher readiness must become a top priority. Despite long-standing and widespread criticism, teacher education at both the preservice and inservice levels remains a sad enterprise. Little of what goes on in the "training" prepares teachers for the difficulties so many encounter at the school site. And the problem is exacerbated by increasing teacher shortages that cause districts to hire individuals with little or no training. All teachers, and especially novices, would benefit greatly from effective mentoring on-the-job, in contrast to sitting in course-oriented programs during off duty hours. Indeed, creating true master practitioner-apprentice relationships is the key to personalizing inservice education. Despite increasing recognition of this matter, however, true mentoring is not in wide use.

In considering context, we must fully appreciate that learning and teaching takes place in several embedded environments: classroom, school, home, neighborhood. It seems self-evident that students and teachers need and deserve environments that are welcoming, supportive, caring, and that address barriers to learning. It is also clear that developing such environments requires effective home-school-community partnerships.

Early-After-Onset Interventions

Doing away with social promotion carries with it a responsibility to identify and provide added supports as soon as a student is seen as having problems. This is sometimes described as "just in time" intervention.

The process of identifying students who need extra assistance is not complicated. If asked, every teacher can easily point out those who are not performing up to existing standards. In some schools, the numbers already identified are quite large. The only thing accomplished by raising the standards is to increase the pool of youngsters who need extra assistance.

What is complicated is providing extra assistance -- especially in schools where large numbers are involved. Currently, in such situations, those with the least severe problems must wait until their problems become severe.

One key to improving early-after-onset responses is to provide teachers with mentors who can demon-strate how to design classrooms that match student motivational and developmental differences. Such mentoring focuses on strategies for personalizing classroom instruction, including creating small classes within big ones, using aides and volunteers to enhance student support and direction, and expanding ways to accommodate and compensate for diversity and disability.

With specific respect to accommodations, it is worth noting that Section 504 of the Rehabilitation Act of 1973 has been revitalized in the last few years. Along with the Individuals with Disabilities Education Act (IDEA), Section 504 is meant to ensure that individuals with disabilities are not discriminated against (see page 8 of this newsletter.) With the reauthorization of IDEA giving the inclusion movement a boost and with renewed interest in enforcing Section 504, there is enhanced emphasis on the topic of accommodations for those with disabilities. All this provides an invaluable window of opportunity not just to improve the ways school's accommodate individuals with disabilities, but how they accommodate *everyone*. To do so, would be in the spirit of Section 504, which after all is a piece of civil rights legislation.

By enabling the teacher to do more, it is reasonable to expect substantial reductions in the number of students who need a bit more support. Such reductions will make it more feasible to offer the remaining youngsters and families the specialized assistance they need. Such an approach also provides a functional strategy for identifying the small group of youngsters whose problems are severe and chronic and who thus require intensive interventions and may even need alternative placements.

Concluding Comments

If moves toward higher standards and eliminating social promotion are to succeed, every school needs a comprehensive and multifaceted set of interventions to prevent and respond to problems early-after-onset. Without such programs, these initiatives can only have a detrimental effect on the many students already not connecting with literacy instruction. Unfortunately, establishing such approaches is excruciatingly hard. Efforts to do so are handicapped by inadequate funding, by the way interventions are conceived and organized, and by the way professionals understand their roles and functions. For many reasons, policy makers currently assign a low priority to underwriting efforts to address barriers to learning. Such efforts seldom are conceived in comprehensive ways and little thought or time is given to mechanisms for program development and collaboration. Organizationally and functionally, policy makers mandate, and planners and developers focus on, specific programs. Practitioners and researchers tend to spend most of their time working directly with specific interventions and samples. Not surprisingly, then, programs to address learning, behavior, and emotional problems rarely are comprehensive, multifaceted, or coordinated with each other. The current state of practice cannot be expected to change without a significant shift in prevailing policies.

Of particular importance is school district policy. School boards and superintendents need to revisit the many fragmented and marginalized policies that are reducing the impact of programs and services designed to enable learning. If we are to do more than simply retain students, reform and restructuring efforts must encompass a "learning supports" (or "enabling") component. Such a component must be treated as a high priority so that it is integrated as an essential facet of all initiatives to raise student achievement.

Because school boards play a critical role in all this, our Center has just produced a report entitled *Restructuring Boards of Education to Enhance Schools' Effectiveness in Addressing Barriers to Student Learning* (see page 9 of this newsletter). Over the coming year, we will make this report a centerpiece of our efforts to interface with school boards. We also will explore with organizations participating in the *Coalition for Cohesive Policy in Addressing Barriers to Development and Learning* how they can join in such an initiative.

We welcome your thoughts on any and all of this.

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I suspect that many children would learn arithmetic, and learn it better, if it were illegal.

John Holt

About Empirically Supported Treatment

A recent, popular movement derived from meta-analyses of research, promoted by manualized treatments, and attractive to managed care is the notion of empirically supported treatments. Many of these are based on metacognitive strategies. Based on criteria for carefully designed studies, treatment outcomes are evaluated and are judged as effective or promising. This is a controversial development. Questions about prematurely ruling out some approaches, the transportability of methods, and the misuse of early results are debated. Because this movement may shape practice, it is good to be aware of this development.

Two basic references are:

- **An Update on Empirically Validated Therapies**

  By: Dianne L. Chambless, William C. Sanderson, Varda Shoham, Suzanne Bennett Johnson, Kenneth S. Pope, Paul Crits-Christoph, Mary Baker, Benjamin Johnson, Sheila R. Woody, Stanley Sue, Larry Beutler, David A. Williams, and Susan McCurry

  In: *The Clinical Psychologist, Volume 49, Number 2*, Spring 1996, pp. 5-18.

- **Evaluating the Treatment Manual as a Means of Disseminating Empirically Validated Psychotherapies**

  By: Michael E. Addis, Clark University

  In: Clinical Psychology: Science and Practice, Volume 4, Number 1, 1997, pp. 1-11.

  The abstract for this article states:

> Psychotherapy manuals evolved from the needs of researchers and are rapidly becoming a major medium for disseminating empirically validated treatments. For manuals to provide an effective means of dissemination, specific issues must be considered, including; (a) efficacy and practitioner adherence in research versus clinical practice (b) the difference between rule-governed adherence to a treatment manual and flexible, integrative practice; and (c) the desired structure and content of treatment manuals. Studies should compare the process and outcome of manual-based treatments in experimental versus clinical settings, and the effects of alternative forms of manual-based training. Systematic description of common factors and clinical strategies can also help to disseminate the effective elements of a treatment.

III. FREQUENTLY IDENTIFIED PSYCHOSOCIAL PROBLEMS; DEVELOPMENTAL VARIATIONS, PROBLEMS, DISORDERS AND INTERVENTIONS

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association.

Just as the continuum of Type I, II, and III problems presented in Section 1A does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff. Therefore, these descriptions provide the bases for the following presentation of five psychosocial problems commonly seen in school settings.

In addition to using material from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* published by the American Academy of Pediatric throughout Part III, we also have incorporated fact sheets from major agencies and excerpted key information from journal articles to provide users with a perspective of how the field currently presents itself.

Contents of Section III A:

Attention Problems

Overview

1. Developmental Variations

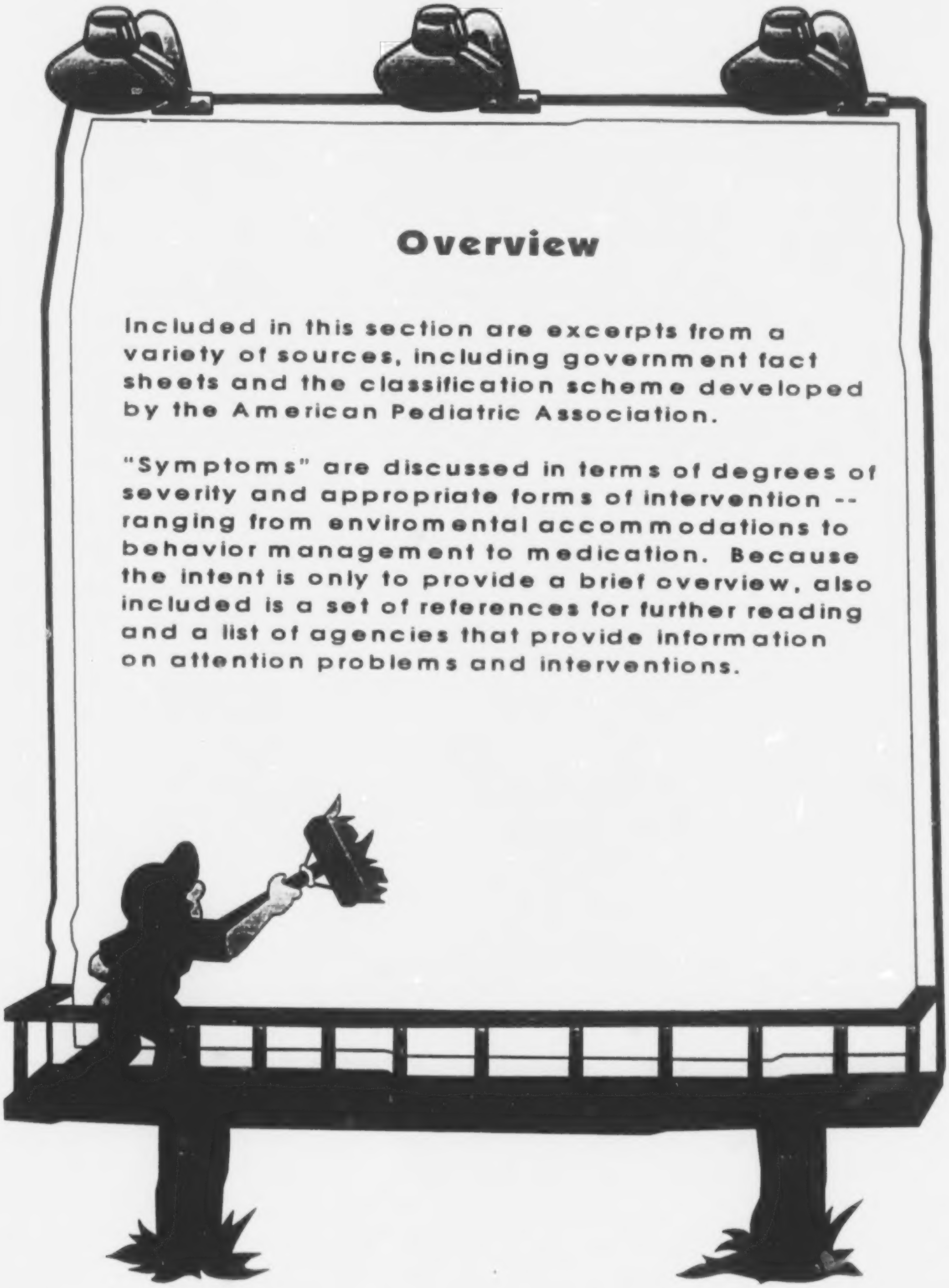
2. Problems

3. Disorders

4. Interventions

    - Accommodations
    - Behavior Management and Self Instruction
    - Empirically Supported Treatment
    - Medication

5. A Few References and Other Sources for Information



Overview

Included in this section are excerpts from a variety of sources, including government fact sheets and the classification scheme developed by the American Pediatric Association.

"Symptoms" are discussed in terms of degrees of severity and appropriate forms of intervention -- ranging from enviromental accommodations to behavior management to medication. Because the intent is only to provide a brief overview, also included is a set of references for further reading and a list of agencies that provide information on attention problems and interventions.

CARING FOR EVERY CHILD'S MENTAL HEALTH
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FACT SHEET

Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the Center for Mental Health Services' Knowledge Exchange Network (see contact information below).

What Is Attention-Deficit/Hyperactivity Disorder?

Young people with attention-deficit/hyperactivity disorder typically are overactive, unable to pay attention, and impulsive. They also tend to be accident prone. Children or adolescents with attention-deficit/hyperactivity disorder may not do well in school or even fail, despite normal or above-normal intelligence. Attention-deficit/hyperactivity disorder is sometimes referred to as ADHD.

What Are the Signs of Attention-Deficit/Hyperactivity Disorder?

There are actually three different types of attention-deficit/hyperactivity disorder, each with different symptoms. The types are referred to as ***inattentive***, ***hyperactive-impulsive***, and ***combined attention-deficit/hyperactivity disorder***.

Children with the ***inattentive*** type:

- have short attention spans;
- are easily distracted;
- do not pay attention to details;
- make lots of mistakes;
- fail to finish things;
- are forgetful;
- don't seem to listen; and
- cannot stay organized.

Children with the ***hyperactive-impulsive*** type:

- fidget and squirm;
- are unable to stay seated or play quietly;
- run or climb too much or when they should not;
- talk too much or when they should not;
- blurt out answers before questions are completed;
- have trouble taking turns; and
- interrupt others.

Combined attention-deficit/hyperactivity disorder, the most common type, is a combination of the inattentive and the hyperactive-impulsive types.

A diagnosis of one of the attention-deficit/hyperactivity disorders is made when a child has a number of the above symptoms, and the symptoms began before the age of 7 and lasted at least 6 months. Generally, symptoms have to be seen in at least two different settings (for example, at home and at school) before a diagnosis is made.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301 443 2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about childrens mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1800 789 2647 • ~~FAX 302 656 4012~~
FAX 301 984 8796 • TTY 301 443 9006 • CMHS Electronic Bulletin Board 1800 790 2647

SAMHSA

How Common Is Attention-Deficit/Hyperactivity Disorder?

Attention-deficit/hyperactivity disorder is found in as many as 1 in every 20 children. Studies have shown that boys with attention-deficit/hyperactivity disorder outnumber girls with the disorder about three to one.[1]

Children and adolescents with attention-deficit/hyperactivity disorder are at risk for many other disorders. About half of all young people with attention-deficit/hyperactivity disorder also have oppositional or conduct disorder, and about a fourth have an anxiety disorder. As many as one-third have depression, and about one-fifth have a learning disability. Sometimes a child or adolescent will have two or more of these disorders in addition to attention-deficit/hyperactivity disorder. Also, children with attention-deficit/hyperactivity disorder are at risk for developing personality disorders and substance abuse disorders when they are adolescents or adults.

Attention-deficit/hyperactivity disorder is a major reason why children are referred for mental health care. Boys are more likely to be referred for treatment than girls, in part because many boys with attention-deficit/hyperactivity disorder also have conduct disorder. The mental health services and special education required by children and adolescents with attention-deficit/hyperactivity disorder cost millions of dollars each year. Underachievement and lost productivity can cost these young people and their families even more.

What Causes Attention-Deficit/Hyperactivity Disorder?

Many causes of attention-deficit/hyperactivity disorder have been studied, but no one cause seems to apply to all young people with the disorder. Factors such as viruses, harmful chemicals in the environment, genetics, problems during pregnancy or delivery, or other things that impair brain development may play a role.

What Help Is Available for Families?

Many treatments—some with good scientific basis, some without—have been recommended for children and adolescents with attention-deficit/hyperactivity disorder. The best proven treatments are medication and behavior treatments.

Medication.[2] The most widely used drugs for treating attention-deficit/hyperactivity disorder are stimulants, such as amphetamine (Dexedrine, Dextrostat, Desoxyn), methylphenidate (Ritalin), and pemoline (Cylert). Stimulants increase the activity in parts of the brain that are underactive in children and adolescents with attention-deficit/hyperactivity disorder. Experts believe that this is why stimulants improve attention and reduce impulsive, hyperactive, or aggressive behavior. Individuals may respond better to one medication than to another. For example, clonidine (Catapres) is often used, although its effectiveness has not been clearly shown. A few antidepressants may also work for some patients. Tranquilizers like thioridazine (Mellaril) have also been shown to work for some young people. Care must be used in prescribing and monitoring all medication.

Like most medications, those used to treat attention-deficit/hyperactivity disorder have side effects. When taking these medications, some children may lose weight, have a smaller appetite, and temporarily grow more slowly. Others may have trouble falling asleep. However, many doctors believe the benefits of medication outweigh the possible side effects. Side effects that do occur can often be handled by reducing the dosage.

Behavior Treatment. Behavior treatments include:

- teaching parents and teachers how to manage and modify the child's or adolescent's behavior, such as rewarding good behavior;
- a daily report card to link the home and school efforts (where the parent rewards the child or adolescent for good school performance and behavior);
- summer and Saturday programs;
- special classrooms that use intensive behavior modification; and
- specially trained classroom aides.

It is clear that both stimulants and behavior treatment can be helpful in the short run (a few weeks or months). However, it is not clear how long the benefit lasts. The Federal Government's National Institute of Mental Health is supporting research on the long-term benefits of various treatments as well as research to find out whether medication and behavior treatment are more effective when combined. There is also research on new medicines and other new treatments. Other Federal agencies carrying out research on attention-deficit/hyperactivity disorder include the Center for Mental Health Services and the Department of Education.

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[1] *This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for this disorder. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.*

[2] *The medications mentioned above in this article are not the only medications which may be prescribed for these disorders.*

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

Can Attention-Deficit/Hyperactivity Disorder Be Prevented?

Because there are so many suspected causes of attention-deficit/hyperactivity disorder, prevention may be difficult. However, it always is wise to obtain good prenatal care and stay away from alcohol, tobacco, and other harmful chemicals during pregnancy and to get good general health care for the child. These recommendations may be particularly important if attention-deficit/hyperactivity disorder is suspected in other family members. Knowing that attention-deficit/hyperactivity disorder is in the family can alert parents to take early action to prevent bigger problems.

What Else Can Parents Do?

When it comes to attention-deficit/hyperactivity disorder, parents and other caregivers should be careful not to jump to conclusions. A high energy level alone in a child or adolescent does not mean that he or she has attention-deficit/hyperactivity disorder. The diagnosis depends on whether the child or adolescent can focus well enough to complete tasks that suit his or her age and intelligence. This ability is most likely to be noticed by a teacher. Therefore, input from teachers should be taken seriously.

If parents or other caregivers suspect attention-deficit/hyperactivity disorder, they should:

- Make an appointment with a psychiatrist, psychologist, child neurologist, or behavioral pediatrician for an evaluation. (Check with the child's doctor for a referral.)
- If the young person is diagnosed with attention-deficit/hyperactivity disorder, be patient. The disorder may take a long time to improve.
- Instill a sense of competence in the child or adolescent. Promote his or her strengths, talents, and feelings of self-worth.
- Remember that failure, frustration, discouragement, low self-esteem, and depression, in many cases, cause more problems than the disorder itself.
- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk with other families in the community.
- Find family network organizations.

It is important that people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available—for free publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006; http://www.mentalhealth.org/

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Hyperactive/Impulsive

Variation

Young children in infancy and in the pre-school years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.

During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.

High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Infants will vary in their responses to stimulation. Some infants may be overactive to sensations such as touch and sound and may squirm away from the caregiver, while others find it pleasurable to respond with increased activity.

Early Childhood
The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.

Middle Childhood
The child plays active games for long periods. The child may occasionally do things impulsively, particularly when excited.

Adolescence
The adolescent engages in active social activities (e.g., dancing) for long periods, may engage in risky behaviors with peers.

SPECIAL INFORMATION

Activity should be thought of not only in terms of actual movement, but also in terms of variations in responding to touch, pressure, sound, light, and other sensations. Also, for the infant and young child, activity and attention are related to the interaction between the child and the caregiver, e.g., when sharing attention and playing together.

Activity and impulsivity often normally increase when the child is tired or hungry and decrease when sources of fatigue or hunger are addressed.

Activity normally may increase in new situations or when the child may be anxious. Familiarity then reduces activity.

Both activity and impulsivity must be judged in the context of the caregiver's expectations and the level of stress experienced by the caregiver. When expectations are unreasonable, the stress level is high, and/or the parent has an emotional disorder (especially depression ...), the adult may exaggerate the child's level of activity/impulsivity.

Activity level is a variable of temperament (...).The activity level of some children is on the high end of normal from birth and continues to be high throughout their development.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Hyperactive/Impulsive

Behavior Problem

These behaviors become a problem when they are intense enough to begin to disrupt relationships with others or begin to affect the acquisition of age-appropriate skills. The child displays some of the symptoms listed in the section on ADHD predominantly hyperactive/impulsive subtype. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder such as ADHD, or of a mood disorder (see section on Sadness and Related Symptoms), or anxiety disorder (see section on Anxious Symptoms).

A problem degree of this behavior is also likely to be accompanied by other behaviors such as negative emotional behaviors or aggressive/oppositional behaviors.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant squirms and has early motor development with increased climbing. Sensory underreactivity and overreactivity as described in developmental variations can be associated with high activity levels.

Early Childhood
The child frequently runs into people or knocks things down during play, gets injured frequently, and does not want to sit for stories or games.

Middle Childhood
The child may butt into other children's games, interrupts frequently, and has problems completing chores.

Adolescence
The adolescent engages in "fooling around" that begins to annoy others and fidgets in class or while watching television.

SPECIAL INFORMATION

In infancy and early childhood, a problem level of these behaviors may be easily confused with cognitive problems such as limited intelligence or specific developmental problems (...). However, cognitive problems and hyperactive/impulsive symptoms can occur simultaneously.

A problem level of these behaviors may also be seen from early childhood on, as a response to neglect (...), physical/sexual abuse (...), or other chronic stress, and this possibility should be considered.

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* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

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3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDER

Attention-Deficit/Hyperactivity Disorder

Predominantly Hyperactive-Impulsive Type

This subtype should be used if six (or more) of the following symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention (...) have persisted for at least 6 months. They present before the age of 7 years. The symptoms need to be present to a significantly greater degree than is appropriate for the age, cognitive ability, and gender of the child, and the symptoms should be present in more than one setting (e.g., school and home).

Hyperactive-impulsive symptoms:

These symptoms must be present to a degree that is maladaptive and inconsistent with developmental level, resulting in significant impairment.

Hyperactivity

- often fidgets with hands/feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

Impulsivity

- often blurts out answers before questions are completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant squirms frequently and has early motor development with excessive climbing. The infant has a hard time focusing on people or objects and squirms constantly. The infant does not organize purposeful gestures or behavior. The infant may show interest in gross motor activities such as excessive climbing but may also have difficulties in motor planning and sequencing (imitating complex movements). However, these behaviors are nonspecific and a disorder diagnosis is extremely difficult to make in this age group.

Early Childhood
The child runs through the house, jumps and climbs excessively on furniture, will not sit still to eat or be read to, and is often into things.

Middle Childhood
The child is often talking and interrupting, cannot sit still at meal times, is often fidgeting when watching television, makes noise that is disruptive, and grabs from others.

Adolescence
The adolescent is restless and fidgety while doing any and all quiet activities, interrupts and "bugs" other people, and gets into trouble frequently. Hyperactive symptoms decrease or are replaced with a sense of restlessness.

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contribution to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce (...)
Physical abuse/sexual abuse (...)
Mental disorder of parent (...)
Other family relationship problems (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

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* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

DISORDER, CONTINUED

Predominantly Hyperactive-Impulsive Type, Continued

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is present in two or more settings (e.g., at school and at home). There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. The symptoms do not occur exclusively during the course of an autistic disorder (see following differential diagnostic information), and are not better accounted for by another mental disorder (see following differential diagnosis information).

Combined Type

This subtype should be used if criteria, six (or more) symptoms of hyperactivity-impulsivity and six (or more) of the symptoms of the inattention (...), have persisted for at least 6 months.

Attention-Deficit/Hyperactivity Disorder, NOS

(see DSM-IV Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS CONTINUED

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contributions to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce, (...)
Physical abuse/sexual abuse, (...)
Mental disorder of parent, (...)
Other family relationship problems, (...)
Loss/bereavement, (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that both contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

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* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

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4. Interventions

On the following pages are discussions of

- Accomodations to Reduce Attention Problems
- Behavior Management and Self Instruction
- Empirically Supported Treatments for Attention Problems
- Medications Used to Treat Attention Problems

Intervention:

Accommodations to Reduce Attention Problems

As one of the identified disabilities covered by Section 504 of the Social Security Rehabilitation Act referred to previously, accommodations for Attention Deficit Hyperactivity Disorder are mandated by law. A good description of such accommodations is included in the excerpts from the following reference article:

Best Practices in Planning Interventions for Students with Attention Disorders. by Margaret M. Dawson. In *Best Practices in School Psychology* (1995) pp 987-998. Thomas, A. and Grimer, J. (Eds.) Washington, D.C.; The National Association of School Psychologists.

◆

> ...Environmental modifications involve changing aspects of the student's environment to address learning or behavior problems. Examples might include seating the student near the teacher for whole-group instruction or allowing the student to come directly in from recess without having to wait in line. Behavioral modification consists primarily of developing incentive systems to increase the likelihood that the student will engage in appropriate classroom behaviors. These interventions are most effectively developed using a problem-solving format. This approach can be used in a one-to-one consultation between school psychologist and teacher or applied in a small group setting. Many school psychologists serve on teacher assistance teams that function in this way. Such an approach generally follows the following steps: (a) define target behaviors specifically; (b) brainstorm possible solutions; (c) select an appropriate intervention; (d) implement the intervention; and (e) evaluate the results. The chapter on behavioral consultation elsewhere in this volume provides further information about this problem-solving model.
>
> This approach can be used with students whose attention problems range from mild to severe, whose needs can be met in the regular classroom with minimal modifications, or who may require something more formal, such as a special education plan or a Section 504 plan. Where something more formal is desired, the outcome of such problem solving may be a written plan that delineates the problem behaviors, the appropriate interventions, or accommodations, and the person(s) responsible for implementing the interventions. Figure 1 provides an example of such a plan...

FIGURE 1. Sample Section 504 plan.

Area of Concern	Intervention/Accommodation
1. Written expression	1. Provide assistance with prewriting activities (brainstorming/concept mapping) 2. Allow use of computer or dictation for longer assignments 3. Provide assistance with proofing, preparing final draft
2. Long assignments	1. Break down long assignments into shorter ones 2. Help student develop time lines for longer assignments 3. Reduce writing requirements by reducing length and allowing alternative methods of demonstrating learning
3. Following directions	1. Provide written as well as oral directions 2. Repeat group directions individually 3. Have student repeat directions to show understanding 4. Break down longer directions into smaller steps 5. Build in incentives for following directions and for asking for help
4. Distractibility	1. Preferential seating during whole class work 2. Nonverbal signal from teacher to attend 3. Quiet place to work during seatwork 4. Cue for transitions 5. Incentives for timely work completion

* * *

Environmental Modifications

With appropriate modifications and accommodations, the educational needs of a majority of students with attention disorders can be met solely or primarily within a regular classroom environment. And while behavior modification strategies can be very effective in improving classroom performance and behavior, altering environmental variables and making task modifications are an important adjunct.

Research on task modifications for students with attention disorders has been conducted primarily by Zentall and her colleagues at Purdue University. Some of their findings that may be relevant to classroom settings are:

1. Stories presented at a faster-than-normal rate of speech resulted in improved listening comprehension and decreased activity level (Shroyer & Zentall, 1986).

2. Using color to highlight salient information increased accuracy and decreased activity level for students with ADHD (Zentall, 1985, 1986).

3. Tasks with a high degree of structure decreased activity level, compared to low-structured, more open-ended tasks (Zentall & Leib, 1985).

4. Active response (i.e., requiring a motor response) resulted in improved performance, compared to more passive response conditions (Zentall & Meyer, 1987).

5. Providing brief, global instructions, instead of lengthy, detailed instructions, produced shorter task completion time and fewer requests for cues (Zentall & Gohs, 1984).

6. Math and reading tasks presented in a low-noise environment created better performance and decreased activity levels than did a high-noise environment (Zentall & Shaw, 1980).

Effective classroom modifications include seating students preferentially, calling on the student frequently during class discussions, writing start and stop times for written work completion, using a kitchen timer as a motivator, and providing the student with a daily checklist of assignments to help organize work assignments. Children with attention disorders, particularly if they have concomitant executive skill deficits, may need help getting started on assignments. This can be done by walking them through the first few items or talking to them about the assignment to help them get oriented. They often do significantly better when tasks are modified to respond to their deficit areas, including presentation of briefer tasks, building in breaks, allowing the opportunity to stand up and move around, and, as noted above, providing high within-task stimulation.

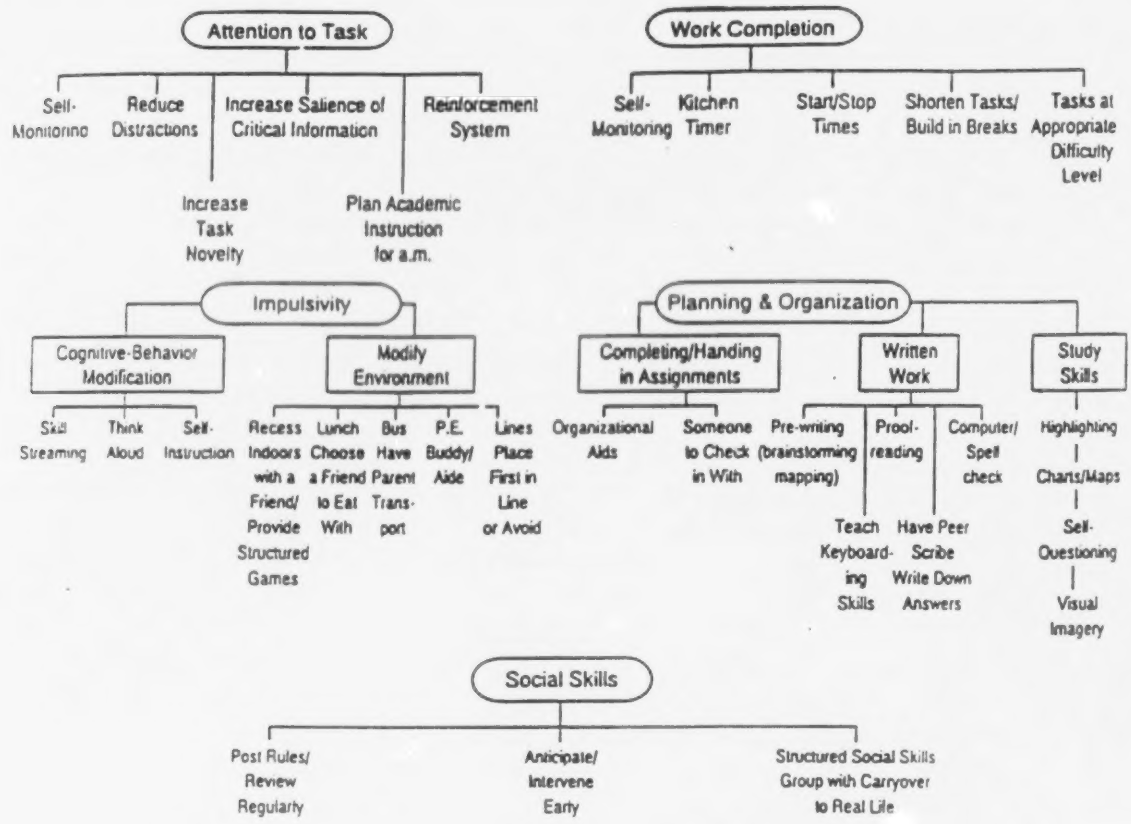
Other modifications for youngsters with ADHD address the fact that they tend to do best when they have frequent opportunities to respond and receive immediate feedback. Peer tutoring and cooperative learning approaches both build in greater opportunities for individual response and immediate feedback than do more traditional classroom structures, such as lectures and individual seatwork activities. Computers also offer great promise for youngsters with ADHD, because levels of response and feedback are increased and because computer software can be novel, entertaining, and interactive.

Modifications that address difficulty in written production include reducing writing requirements, allowing students to dictate or tape record assignments, and allowing for alternative means of demonstrating knowledge or learning, such as projects and oral reports. Providing access to computers to learn word processing and to complete written assignments is an essential modification for many youngsters with ADHD.

Still other modifications address the fact that youngsters with ADHD do more poorly with tasks they find tedious, difficult, or uninteresting. These modifications include reducing repetitive seatwork and making tasks and assignments as appealing as possible. Youngsters with ADHD respond very well to activities with a game format or to lessons that are presented as problems to be solved, particularly if they have real-life applications. Project-oriented learning is ideally suited to the learning style of many youngsters. Others respond to the opportunity to design their own assignments. Independent learning projects can be particularly effective at the secondary level. Allowing students to negotiate their own learning contract can increase motivation and enhance performance — another modification that may be especially effective at the secondary level.

Giving these students choices—in terms of *what* assignments they will do, *how* they will do them, *in what order, where,* and with *whom* they will complete the work—can have a dramatic impact on productivity and task completion. And pairing youngsters with ADHD with other students allows them to use complementary strengths. A youngster with ADHD may have very creative ideas but have trouble putting them down on paper, while another student may be skilled at organizing work and writing but lack imagination; by pairing the two, both can benefit —and learn—from the strengths of the other.

Figure 4. School-based interventions for children with attentional problems.


Attention to Task
Self-Monitoring
Reduce Distractions
Increase Salience of Critical Information
Reinforcement System
Increase Task Novelty
Plan Academic Instruction for a.m.
Work Completion
Self-Monitoring
Kitchen Timer
Start/Stop Times
Shorten Tasks/ Build in Breaks
Tasks at Appropriate Difficulty Level
Impulsivity
Cognitive-Behavior Modification
Skill Streaming
Think Aloud
Self-Instruction
Modify Environment
Recess Indoors with a Friend/ Provide Structured Games
Lunch Choose a Friend to Eat With
Bus Have Parent Transport
P.E. Buddy/ Aide
Lines Place First in Line or Avoid
Planning & Organization
Completing/Handing in Assignments
Organizational Aids
Someone to Check in With
Written Work
Pre-writing (brainstorming mapping)
Proofreading
Computer/ Spell check
Teach Keyboarding Skills
Have Peer Scribe Write Down Answers
Study Skills
Highlighting
Charts/Maps
Self-Questioning
Visual Imagery
Social Skills
Post Rules/ Review Regularly
Anticipate/ Intervene Early
Structured Social Skills Group with Carryover to Real Life

While we generally think about classroom and task modifications in terms of the learning weaknesses of youngsters with attention disorders, the strengths these students have must not be neglected. It is critically important for those who work with these students to identify their skills, aptitudes, and talents, to find ways to encourage their development, and to ensure that these students are recognized for their accomplishments. Youngsters with attention disorders tend to receive negative feedback in greater quantities than their classmates. Special efforts must counteract these threats to self-esteem by finding areas where these students can shine.

This is a brief summary of the kinds of instructional and task modifications that are employed frequently with youngsters with attention disorders. Figure 4 contains examples of other modifications that may be appropriate.

Support Services

While the interventions described above may be sufficient for most youngsters with attention disorders, others will require additional support services to meet their needs. Students with attention disorders may qualify for these services either through

Section 504 of the Rehabilitation Act (which protects students who have a physical or mental impairment "that substantially limits one or more major life activities," such as learning) or through the Individuals with Disabilities Education Act, IDEA, through the disability category Other Health Impaired. Under Section 504, school districts develop an accommodation plan that defines what services are needed and how they will be provided. Under IDEA, these services are specified in the student's Individual Education Plan (IEP).

While the need for special education or other services is often determined on the basis of a discrepancy between scores on measures of ability and achievement, with children with attention disorders, the central issue is more often a problem with *daily classroom performance*, and it is on this basis that the need for services should be determined.

Support services, provided either through Section 504 or IDEA, may include any of the following:

1. A monitor with whom the student can check in one or more times a day. This approach often is employed at the secondary level, where students change classes and have many teachers, and may, as a result, have difficulty keeping track of assignments, materials, and possessions. A monitor helps ensure that the student hands in homework assignments, is prepared for class, and has the necessary materials for class participation and homework completion. Monitors can also help manage home-school report cards when they are used.

2. Supervised study halls, to ensure that students use this time wisely and can receive assistance with assignments as needed.

3. Help with study and organizational skills, either through tutoring, in a supervised study hall, or through participation in study skills courses. This may include assistance with setting up and keeping an assignment notebook, using memory aids, planning long-term assignments, monitoring progress on long-term assignments, and learning note-taking skills, time-management skills, and study and test-taking skills.

4. A classroom aide to help make task modifications, increase student time on task, intervene in response to disruptive behavior, and administer reinforcement systems.

5. Remedial instruction in areas of academic skill deficit.

6. Counseling services to address social emotional needs, such as participation in social skills groups.

While these are all direct services, students with attention disorders are also entitled to indirect services, such as consultation for the classroom teacher from a special education teacher, counselor, or school psychologist.

Other Roles for School Psychologists

The school psychologist can play a critical role in designing appropriate interventions for students with attention disorders. Other roles that are well suited to the skills and training of school psychologists include:

1. Acting as a liaison among the home, the school, and other service providers, such as mental health workers and physicians.

2. Case managing, including follow-up to assess intervention effectiveness, data collection to monitor medication effects, and

help with transitions to the next grade level, school, and the like.

3. Providing training and information to parents concerning the management of attention disorders in the home.

4. Providing in-service training for teachers.

5. Becoming involved with advocacy groups for parents of children with attention disorders. Besides becoming a valuable resource to such groups, this can have good public relations benefits for the school psychologist and the school district where he or she is employed.

* * *

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This comprehensive volume addresses both diagnostic and treatment issues related to ADHD. It is perhaps the most comprehensive single volume addressing attention disorders and is highly recommended for an professionals who work with students with ADHD. The book is divided into three sections, with Part 1 addressing the nature and diagnosis of ADHD, Part 2 addressing assessment issues, and Part 3 devoted to treatment issues. Part 3 includes chapters on counseling and training parents, educational placement and classroom management, social skins and peer relationship training, and medication therapy.

Fiore, T. A., Becker, E. A., & Nero, R. C. (1993). *Research synthesis on educational interventions for students with ADD.* Research Triangle Park, NC: Research Triangle Institute. This volume, prepared by one of the federally funded ADD Intervention Centers, contains a comprehensive summary of research on educational interventions for students with ADHD. Research is divided into seven topics: positive reinforcement, behavior reduction, response cost, cognitive-behavioral interventions, parent training, task/environmental stimulation, and biofeedback. For each topic area, the authors present a brief synopsis of research findings with suggestions for educators and areas for further study and a chart summarizing each research study reviewed. The rest of the volume consists of an annotated bibliography of the research studies.

Guevremont, D. C. (1992, Fall/Winter). The parents' role in helping the ADHD child with peer relationships. *CHADDER,* p. 17

This article, written for parents by an associate of Russell Barkley, outlines the social behaviors common to children with ADHD and then gives parents useful suggestions for improving social skill and enhancing their children's ability to make and keep friends. It describes a home reward program that is relatively easy to administer and goes on to suggest practical ways that parents can arrange for positive experiences with peers both at home and in the community. It concludes with suggestions for how parents may work with teaches to enhance social skills and positive peer interactions. It makes a useful handout that school psychologists can give to parents.

Teeter, P. K. (Guest Ed.). (1991). Mini-series: Attention-deficit hyperactivity disorders in children: Clinical and treatment Issues. *School Psychology Review, 20,* 161-281.

This volume of *School Psychology Review* contains nine articles on a variety of topics associated with ADHD, written by the leading researchers in the field. In addition to articles on diagnosis and assessment, four articles address treatment issues. These include therapeutic effects of medication, classroom-based behavioral interventions, remediating social skills deficits, and training for parents of children with ADHD. Each of these articles provides a concise synopsis of current thinking and research as well as practical information the practicing school psychologist will find useful.

Intervention:

Behavior Management & Self-Instruction

A popular approach for working with youngsters with attention problems in classrooms was summarized in LD Forum, Vol 20 (4), Summer, 1995, by Jacqualine Berger. The following excerpt from her article captures the idea of this approach.

> ...Cognitive behavior modification (CBM) is a strategy that has proved effective for students who need to develop self control. Meichenbaum pioneered the work on CBM in the late 1960s and early 1970s and, in conjunction with Goodman (1971), developed a self-instruction training program. CBM stresses the importance of language in cognitive and behavioral development. Quite simply, Meichenbaum believed that people who talk themselves through situations are better able to control their behavior. Those who don't have this ability can learn it. The program that Meichenbaum developed was based on the idea that inner speech is an important part of the thinking process, and that children can use inner speech in a self-guiding fashion. In CBM programs, children are taught to think before they act and to produce self-instruction. This strategy can be used by teachers and children to focus on both behaviors and academic tasks. They STOP! They THINK! Then they ACT...
>
> ...To self-instruct, the learner progresses through a series of steps that moves from external overt (outloud) controls to internal covert (silent) controls. These steps are presented in Table 1. Self-instruction training steps are organized into three primary stages: self-talk modeling by the teacher, self-talk steps imitated by the student, and independent use of self-talk by the student...
>
> **USING SELF-INSTRUCTION**
>
> Self-instruction can be an effective technique to use in the classroom. A teacher should work with children individually or in small groups and begin with simple concrete tasks...."

Table 1. Steps for Teaching Self-Instruction

1. Cognitive Modeling	The teacher models a task while talking outloud.
2. Overt External Guidance	The teacher talks outloud while the students do what the teacher says.
3. Overt Self-Guidance	The students perform the task while talking out loud.
4. Modeled Faded Overt Self-Guidance	The teacher models the behavior while whispering the instructions.
5. Faded Overt Self-Guidance	The students whisper instructions to themselves while performing the task.
6. Modeled Faded Covert Self-Instruction	The teacher models covert instruction.
7. Covert Self-Instruction	The students perform the task while using private speech.

SELF-INSTRUCTION PROCEDURES

Cognitive Modeling

Initially, the teacher's speech controls and directs the students' behavior. Therefore, the first stage in this step requires that students observe the teacher as he or she models or performs a task while talking outloud. In this thinking-out-loud stage, the teacher defines the problem, asks questions, chooses a plan, shows how the plan is carried out, and self-reinforces. For example, a teacher can talk through staying on task using the following sequence:

1 "I need to stop and define the problem I was told to do the math paper"
2 "I need to think, plan, then act Where's the paper? O.K. I'm looking at the paper Now what do I have to do? I have my pencil I should do the first problem I shouldn't look at the other problems I should just focus on the first one, 1+2=3"
3 "I need to reinforce myself. Good, I finished that one."
4 "I need to stop again Now what do I have to do? Now I should do the next problem"
5 "I need to think, plan, then act until I am finished OK, I finished the paper."
6 "I need to reinforce myself Good, I did a good job"

Overt External Guidance

Next, the students perform the same task while listening to the teachers self-instructions. The students imitate the teacher while the teacher is using overt self-instruction, that is, talking aloud. The students do the math paper while the teacher self-instructs by saying "I was told to do the math paper. Where's the paper? O.K. I'm looking at the paper. Now what do I have to do? I have my pencil. I should do the first problem. I shouldn't look at the other problems. I should focus on the first one, 1+2 =3. Good, I finished that one. Now next problem. I finished the paper. Good, I did a good job."

Overt Self-Guidance

Next, the students perform the task while instructing themselves outloud. They can use dialogue similar to that modeled by the teacher.

Fading Overt Self-Guidance: Modeled and Imitated

Next, the teacher models the same task, self-instructing in a whispered voice. The students then whisper the self-instructions while performing the task.

Modeled Covert Self-Instruction

Finally, the teacher models the last stage, covert (silent) instruction. She performs the task using inner speech, talking herself through the task silently. The students watch the teacher complete the page without hearing her say anything, but she reminds the students that she is using silent seif-instruction.

Covert Self-Instruction

The students then perform the task while using inner speech to guide their performance. They complete the math paper while silently telling themselves what to do.

ENHANCING THE SUCCESS OF SELF-INSTRUCTION TRAINING

The self-instruction sequence contains several elements that are important to performance, including defining the problem, focusing attention and,guiding oneself, reinforcement, and self-evaluation (Mahoney, 1974). A key element to successful use of this strategy by children is rehearsal. During each step, students either listen to or recite the self-instruction. They repeat the entire sequence several times so that CBM becomes automatic. For students to become successful at controlling their behavior with CBM, training and practice for a variety of similar and dissimilar tasks are necessary. Continuously training and practicing those steps will make self-instruction automatic for students, allowing them to use these strategies in new academic and social situations. Students who are skilled in self-instruction can better control their behavior and contribute to a positive learning atmosphere.

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Intervention:

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Empirically Supported Psychosocial Treatments for Attention Deficit Hyperactivity Disorder" by W.E. Pelham, Jr., T. Wheeler, & A. Chronis, which appears in the *Journal of Clinical Child Psychology*, *27*, 190-205.

Excerpted here are the abstract, an adapted table categorizing relevant research, the authors' conclusions, and the authors' reference list.

Abstract of article by W.E. Pelham, Jr., T. Wheeler, & A. Chronis, which appears in the *Journal of Clinical Child Psychology*, *27*, 190-205.

Reviews and evaluates psychosocial treatments for attention deficit hyperactivity disorder (ADHD) in children and adolescents according to Task Force Criteria (Lonigan, Elbert, & Johnson, this issue). It is concluded that behavioral parent training and behavioral interventions in the classroom meet criteria for well-established treatments. Cognitive interventions do not meet criteria for well-established or probably efficacious treatments. Issues regarding the evaluative process are discussed and future directions for psychosocial treatment for ADHD are outlined.

The authors note:

"Phamacological treatments for ADHD are far more widely employed, are less expensive, and have much more short-term empirical support than psychosocial treatments." (p. 191)

"All of the psychosical treatments that we found in our searches would be labeled as behavioral or cognitive behavioral...(a) clinical behavior therapy; (b) direct contingency management; (c) cognitive behavioral intervention; and (intensive, packaged behavioral treatments." (p. 193)

The excerpts on the following pages highlight the gist of this work.

Table 1. *Categorization of Studies Reviewed*

I. Behavioral Parent Training:
Studies That Contribute to Meeting Task Force Criteria for Well-Established Treatment

A. Studies Employing	***N***	**Control Conditions**	**Measures** [a]
1. Firestone et al. (1981), with Firestone et al. (1986) [a]	1981: 43; 1986: 52 1st, 30 2nd	Methylphenidate	2, 3, 6, 8, 9
2. Gettelman et al. (1980) (partial *N* in 1976; expanded *N* in 1984 and 1985, in press) [a]	89 (95% male)	Methylphenidate	2, 5, 6, 8, 12
3. Horn et al. (1990)[a]	42 (81% male)	Self-control therapy	2, 6, 8, 9, 11
4/5. Horn et al. (1991) with Ialongo et al., 1993 (follow-up)[a]	96 (77% male)	Methylphenidate, Self-control therapy	2, 3, 5, 6, 8, 9, 11
6. Pelham et al. (1988)[a]	32 (88% male)	Methylphenidate,	2, 5, 6, 8, 10

B. Studies Employing Single-Subject Designs: None

II. Behavioral Parent training:
Studies That Contribute to Meeting Task Force Criteria for Probably Efficacious Treatment

A. Studies Employing	***N***	**Control Conditions**	**Measures** [b]
1. Anastopoulos et al. (1993)	34 (74% male)	Wait-list control group	2, 3, 4
2. Pesterman et al. (1989)	46 (80% male)	Wait-list control group	1
3. Pisterman et al. (1992b)	45 (93% male)	Wait-list control group	1, 2, 3
4. Pisterman et al. (1992 a) additional measures and follow-up from #2 and #3)	91 (86% male)	Wait-list control group	1, 2, 3
5. Dubey, O'Leary, & Kaufman (1983)[c]	37 (87% male)	Parent effectiveness training,	1, 2, 3, 13

• • •

Note: [a] Efficacious depending on measure and must collapse over groups to have sufficient total sample size. [b] Dependent measures: 1 = parent-child observations; 2 = parent ratings; 3 = parental functioning; 4 = family functioning; 5 = classroom observations; 6 = teachers ratings; 7 = academic productivity; 8 = academic achievement; 9 = cognitive tests; 10 = peer relationships; 11 = child self-ratings; 12 = clinician ratings; 13 = consumer satisfaction ratings; 14 = behavior frequency counts; 15 = activity level measures. [c] Treatments equal and superior to wait-list. [d] All treatments showed equal improvement. [e] Depends on subject and dependent measure. [f] Effects not clearly apparent.

IV. Behavioral Modification in Classroom Settings:
Studies That Contribute to Meeting Task Force Criteria for Well-established Treatment

A. Studies Employing Between-Group Designs	*N*	**Control Conditions**	**Measures**[a]
1. Gittleman et al. (1980) (partial *N* in 1976; ex-	89 (95% male)	Methylphenidate	2, 5, 6, 8, 12
2. Pelham et al. (1988)[b]	32 (88% male)	Methylphenidate, social skills training	2, 5, 6, 8, 10
B. Studies Employing Single-Subject Designs	*N*	**Control Conditions**	**Measures**[a]
1. Abramowitz et al. (1992)	3 (100% male)	Methylphenidate, delayed vs. short reprimands	5
2. Abramowitz & O'Leary (1990)	4 (100% male)	Delayed reprimands, reversal	5
3. Abramowitz et al. (1988)	7 (100% male)	Short vs. long reprimands	5, 7
4. Abramowitz et al. (1987)	16 (75% male)	Encouragement vs. reprimands, no-	5, 7
5. Atkins et al. (1989)	1 (male)	No-treatment reversal, multiple	5, 7, 10
6. Ayllon, Layman, & Kandel (1975)	3 (67% male)	Methylphenidate	5, 7
7. Barkley, Copeland, & Sivage (1980)[c]	7 (100% male)	No-treatment reversal	5, 15
8. Broden, Bruce, Mitchell, Carter, & Hall	2 (100% male)	No-treatment reversal	5
9. Carlson et al. (1992)	24 (100% male)	Methylphenidate,	5, 7, 11
10. Gordon, Thamason, Cooper, & Ivers (1991)	6 (50% male)	No-treatment reversal	5
11. Hoza et al. (1992)	2 (100% male)	Methylphenidate, increased	5, 7
12. Kelley & McCain (1995)	5 (40% male)	No-response cost reversal	5, 7, 13
13. Loney, Weissenberger, Woolson, & Lichty	12 (100% male)	Methylphenidate,	5
14. McCain & Kelley (1993)	1 male	No-treatment reversal	5
15. Pelham et al. (1993)	31 (100% male)	Methylphenidate,	5, 6, 7
16. Rapport, Murphy, & Bailey (1980)	2 (50% male)	No-treatment reversal,	5, 7
17. Rapport et al. (1982)	2 (100% male)	Methylphenidate, reversal	5, 6, 7
18. Rosen et al. (1984)	23 (over 3 studies)	No-treatment reversal	5, 7
19. Sullivan & O'Leary (1990)	10 (50% male)	Reward versus response cost	5
20. Umbreit (1995)	1 (male)	No-treatment baseline	5
21. Wolraich et al. (1978)	20	Methylphenidate, regular	5, 6, 7

V. Behavioral Modification in Classroom Setting:
Studies That Contribute to Meeting Task Force Criteria for Probably Efficacious Treat-

A. Studies Employing Between-Group Designs	***N***	**Control Conditions**	**Measures**[a]
1. O'Leary et al. (1976)	17	Wait-list control group	6
B. Studies Employing Single-Subject Designs: None			

VI. Behavioral Modification in Classroom Settings: Studies That Do Not Contribute to Meeting Task Force Criteria for Well-Established or Probably Efficacious Treatment

A. Studies Employing	***N***	**Control Conditions**	**Measures**[a]
1. O'Leary & Pelham (1978)	7	Pre-post	2, 5, 6
2. Pelham et al. (1980)	8 (88% male)	Methylphenidate	1, 2, 5, 6
3. Rosenbaum, O'Leary, & Jacob (1975)	10	Pre-post	6, 13

B. Studies Employing	***N***	**Control Conditions**	**Measures**[a]
1. DuPaul et al. (1992)[f]	2 (100% male)	No-treatment reversal	5, 6, 7
2. DuPaul & Henningson (1993)[f]	1 (male)	No-treatment reversal	5, 7
3. Evans et al. (1995)[f]	1 (male)	No-treatment reversal	5
4. Pollard et al. (1983)[f]	3 (100% male)	Methylphenidate,	2, 4, 5

C. Numerous studies support the effectiveness of behavior therapy in the classroom, but the participant groups are too heterogeneous

1. Acker & O'Leary (1987)
2. Acker & O'Leary (1988)
3. Becker, Madsen, Arnold, & Thomas (1967)
4. Bowers et al.
5. Clark et al. (1973)
6. Hops et al (1978)
7. Hundert, Bucher, & Henderson (1976)
8. Iwata & Bailey (1974)
9. Kauffman & O'Leary (1972)
10. Kent & O'Leary (1976)
11. Lovitt & Curtiss (1969)
12. O'leary et al. (1970)
13. Pfiffner & O'Leary (1987)
14. Pfiffner, O'Leary et al. (1985)
15. Pfiffner, Rosen et al. (1985)
16. Robinson et al. (1981)
17. Stableford et al. (1976)
18. Thomas et al. (1968)
19. Van Houten et al. (1982)
20. Walker et al. (1975)

(p. 200)

* * *

" We conclude this article with a brief discussion of some key questions that remain to be answered and problems that remain to be solved with respect to psychosocial treatments for ADHD. We also briefly discuss current initiatives and trends in the field that impact on psychosocial treatments for ADHD.

The first point is that despite the evidence for the efficacy of behavioral treatments for ADHD, these interventions have limitations, and these limitations are in many ways similar to those of psychostimulant medication that we previously discussed (Pelham & Murphy, 1986). First, behavioral treatments, although effective, do not typically normalize ADHD children (Abikoff & Gittelman, 1984), with posttreatment levels usually being standard deviation above normative means (e.g., Pelham et al., 1988). The short-term effects of behavioral interventions are typically limited to the periods when the programs are actually in effect; when treatment is withdrawn, children often lose the gains made during treatment. Such findings highlight the importance of extending treatments past an initial period to maintain initial gains. Unfortunately, few studies have implemented maintenance strategies into their treatment protocols. Few studies have yet shown maintenance of treatment gains beyond a few months after therapy is terminated (cf. Ialongo et al., 1993).

Furthermore, a substantial minority of children(comparable to the proportion cited for stimulant medication) fail to show improvement (e.g., Pelham et al., 1988). In many cases such failure may be attributable to the unwillingness or inability of parents and teachers to implement the behavioral programs as directed, with noncompliance and dropout from treatment common outcomes (Fuchs & Fuchs, 1989; Prinz & Miller, 1994; Wahler, 1980; Witt, 1986). Even when parents and teachers apparently comply with treatment, manipulation checks of whether they actually follow through with treatment have rarely been conducted.

Just as some of the limitations of medication can be removed by increasing the dosage, the effects of behavior therapy can be maximized by increasing the power and comprehensiveness of the intervention. The standard clinical behavior therapy approach involving weekly contact with parents and teachers is less potent than are highly structured, closely monitored, contingency-management programs. Because it is quite time-consuming and difficult to conduct such systems unassisted, however, parents and regular classroom teachers are typically much less willing to implement complex contingency-management programs.The efficacy of behavior therapy thus depends on the motivation and capabilities of the significant adults in the child's life, as well as setting barriers to implementation, and on the skills of the interveners in overcoming such obstacles. If key adults are unwilling or unable to implement the interventions, and if the objections or obstacles to intervention cannot be overcome, then behavior therapy will not be *effective* in real-world settings, despite the empirical evidence for its *efficacy* in empirical studies. ...

As we have written elsewhere, multimodal treatment, in which a low dose of stimulant medication is combined with behavioral treatments, may be the most effective and most cost-effective treatment for ADHD. A number of short-term studies have shown that lower medication doses with fewer side effects can be integrated with less intensive, less complex, and therefore less expensive psychosocial treatments to yield a combined package with short-term efficacy equivalent to that produced by high and therefore undesirable doses of medication and to that yielded by complicated and expensive behavioral treatments (Pelham & Murphy, 1986; Pelham & Waschbusch, in press). Unfortunately, no long-term outcome data exist regarding efficacy or effectiveness of pharmacological versus psychosocial versus combined treatments. It is becoming increasingly important to answer cost- benefit questions in the current era of managed care and health care reform, and studies of the cost-effectiveness of behavioral and multimodal treatments are badly needed.

An important but relatively unstudied aspect of behavioral treatments for ADHD is their exportability to clinic settings-the issue of efficacy versus effectiveness (Hoagwood, Hibbs, Brent, & Jensen, 1995; Weisz et al., 1995). Although most of the studies we reviewed were conducted in hospital or clinic settings, they were usually university-based hospitals and clinics. There are undoubtedly differences between the staff and resources of such clinics and those of community mental health settings. As Weisz et al. (1995) noted, such factors likely lead to an overestimation of the effectiveness of behavioral treatments for ADHD as they are likely to be conducted in the mental health system. Research on the exportability of behavioral treatment and their effectiveness in real-world settings needs to be conducted.

Finally, and perhaps most important, the long-term effects of different types of behavioral and combinations of behavioral and pharmacological therapy need to be studied. The short-term efficacy of most types of behavior therapy is well documented. However, virtually no studies have yet examined whether these short-term improvements have any substantial impact, either alone or in combination with medication, on the long-term outcome of children with ADHD. Given the chronicity and poor outcome of ADHD, the answer to this question is critical. As we have discussed, the answer may very well differ depending on the intensity of the behavioral treatment, the consistency, duration, and scope with which it was administered, and whether appropriate pharmacological treatments were adjunctively applied. It is somewhat disconcerting to note that maintenance of short-term behavioral treatment gains has been the pressing question in treatment for disruptive behavior for the past 30 years (e.g., Stokes & Baer, 1977). Most of the between-group studies cited in Table 1 were conducted during the mid- to late 1970s, but no research on long-term maintenance of behavioral treatments for ADHD has been conducted during the intervening 2 decades. ...

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Intervention:

PSYCHOTROPIC MEDICATIONS CATEGORIZED BY CHILD /ADOLESCENT DIAGNOSIS*

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

I. Diagnosis: Attention Deficit-Hyperactivity Disorder (ADHD)
Medication Types and Treatment Effects

A. *Stimulants*

Used as one part of a total treatment regimen that typically includes other remedial measures (psychological, educational, social) to address a behavioral syndrome characterized in terms of developmentally inappropriate symptoms including moderate- to-severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. Stimulants are used with youngsters six years and older to improve attention span and decrease hyperactivity and impulsivity.

B. *Antidepressants*

Anti-depressants such as imipramine are approved for use in treating symptoms of depression in adolescents and adults. Use with children is restricted to treatment of enuresis of those at least 6 years old. Manufacturers state that a maximum dose of 2.5 mg/kg should not be exceeded in children (PDR, 1997). Although imipramine does not have FDA approval for use in ADHD, some clinicians consider it the next drug of choice for those not responding to stimulants; thus they prescribe it to improve mood and decrease hyperactivity. The effects usually are sedating and do not appear to improve concentration (Green, 1995).

C. *Adenergic antagonists*

These are centrally acting antihypertensive agents. The only therapeutic indication that has been approved by the FDA for advertising is treatment of hypertension in older adolescents and adults; its safety and efficacy in children have not been established. Some physicians regard adenergic antagonists such as clonidine as a possible alternative treatment for ADHD for those who do not respond well or who develop severe negative side effects when using stimulants (Green, 1995).

*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitoring of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/insomnia and related factors that can interfere with effective school performance.

Names: Generic (Commercial)	**Some Side Effects and Related Considerations**
A. Stimulants	
methylphenidate hydrochloride [Ritalin]	May manifest nervousness, dizziness, insomnia or drowsiness, tics, palpitations, loss of appetite, nausea, dermatitis, mood changes, growth suppression. If loss of appetite is a problem, administration of medication is recommended after meals. The last dose for a day is to be taken before 6 p.m. to preven, insomnia. Discontinuation is recommended if no improvement in one month. Periodic drug-free periods are recommended to assess efficacy.
dextroamphetamine sulfate [Dexedrine, Femdex, Dexampex]	May manifest restlessness, nervousness, hyperactivity, dizziness, insomnia, unusual fatigue, headache, palpitations, loss of appetite, weight loss, nausea, dry mouth, mood changes, hypersensitivity. The last dose for a day is to be taken before 6 p.m. to prevent insomnia. Periodic reductions in dosage or drug-free periods are recommended to assess efficacy. Gradual discontinuation is recommended if the medication has been used for a long-period.
magnesium pemoline [Cylert]	May manifest dizziness, irritability, insomnia, fatigue, tics, loss of appetite, nausea, weight loss, mild depression, seizures headache, abdominal discomfort. Long-term use may affect the liver and can produce physical and psycho logical dependence. Administration of medication is recommended for the morning to avoid insomnia. Periodic reductions in dosage or drug-free periods are recommended to assess efficacy. Liver function studies are recommended for long-term users.
B. Anti-depressants	
imipramine hydrochloride [Tofranil]	May manifest sedation, drowsiness, dizziness, headache, nausea, fatigue, dty mouth, constipation, heartburn, excessive weight gain, rash, excessive sweating, photosensitivity. Youngster is to move slowly from sitting or lying down positions. Care must be taken to minimize exposure to strong sun. Gradual discontinuation is recommended if the medication has been used for a long period.
C AdenergicAntagonist	
clonidine hyperchloride [Catapres]	May manifest sedation, dizziness, headache, nausea, anxiety, restlessness, nightmares, dry mouth, weight gain, constipation. Sudden discontinuation may cause blood pressure to shoot up.
Guanfacine [Tenex]	Use may lead to tiredness, headaches, stomach aches, and decreased appetite. Not recommended under age 12 as safety and efficacy have not been proven.

Medication and
ATTENTION DEFICIT-HYPERACTIVITY DISORDER

From the National Institute of Mental Health Website: Http://www.nimh.nih.gov/publicat/
The material has been abridged for use here to highlight information about psychotropic medication frequently prescribed for children and adolescents.

Cylert is available in one form, which naturally lasts 5 to 10 hours. Ritalin and Dexedrine come in short-term tablets that last about 4 hours, as well as longer-term preparations that last through the school day. The short-term dose is often more practical for children who need medication only during the school day or for special situations, like attending church or a prom, or studying for an important exam. The sustained-release dosage frees the child from the inconvenience or embarrassment of going to the office or school nurse every day for a pill. The doctor can help decide which preparation to use, and whether a child needs to take the medicine during school hours only or in the evenings and on weekends, too.

Other types of medication may be used if stimulants don't work or if the ADHD occurs with another disorder. Antidepressants and other medications may be used to help control accompanying depression or anxiety. Clonidine, a drug normally used to treat hypertension, may be helpful in people with both ADHD and Tourette's syndrome. Although stimulants tend to be more effective for some forms of the problem, clonidine may be used when stimulants don't work or can't be used. Clonidine can be administered either by pill or by skin patch and has different side effects than stimulants. The doctor works closely with each patient to find the most appropriate medication.

Some doctors recommend that children be taken off a medication now and then to see if the child still needs it. They recommend temporarily stopping the drug during school breaks and summer vacations, when focused attention and calm behavior are usually not as crucial. These "drug holidays" work well if the child can still participate at camp or other activities without medication.

Children on medications should have regular checkups. Parents should also talk regularly with the child's teachers and doctor about how the child is doing. This is especially important when a medication is first started, re-started, or when the dosage is changed.

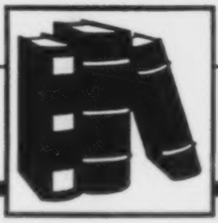
The Medication Debate

As useful as these drugs may be, Ritalin and the other stimulants have sparked a great deal of controversy. Most doctors feel the potential side effects should be carefully weighed against the benefits before prescribing the drugs. While on these medications, some children may lose weight, have less appetite, and temporarily grow more slowly. Others may have problems falling asleep. Some doctors believe that stimulants may also make the symptoms of Tourette's syndrome worse, although recent research suggests this may not be true. Other doctors say if they carefully watch the child's height, weight, and overall development, the benefits of medication far outweigh the potential side effects. Side effects that do occur can often be handled by reducing the dosage.

It's natural for parents to be concerned about whether taking a medicine is in their child's best interests. Parents need to be clear about the benefits and potential risks of using these drugs. The child's pediatrician or psychiatrist can provide advice and answer questions.

Another debate is whether Ritalin and other stimulant drugs are prescribed unnecessarily for too many children. Remember that many things, including anxiety, depression, allergies, seizures, or problems with the home or school environment can make children seem overactive, impulsive, or inattentive. Critics argue that many children who do not have a true attention disorder are medicated as a way to control their disruptive behaviors. Careful assessment and ongoing monitoring by a mental health professional may help to counter these concerns.

(A variety of resources are listed on the next page)



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Books for Parents

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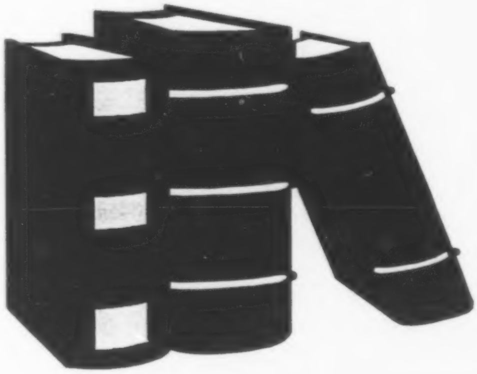

* See references in previous excerpted articles.

Agencies and Online Resources Relevant to Attention-Related Problems and Disorders

The American Academy of Child & Adolescent Psychiatry

The American Academy of Child & Adolescent Psychiatry represents over 5,600 child and adolescent psychiatrists - physicians with at least five years of additional training beyond medical school in general and child and adolescent psychiatry. AACAP members actively research, diagnose, and treat psychiatric disorders affecting children and adolescents and their families, and the Academy is dedicated to supporting this work through a variety of programs including government liaison, national public information and continuing medical education.

Contact: 3615 Wisconsin Avenue, N.W., Washington, DC 20016-3007
Ph.1-202-966-7300 / fax 1-202-966-2891 E-mail: communications@aacap.org
Web: http://www.aacap.org/

The Attention Deficit Information Network, Inc. (AD-IN)

The Attention Deficit Information Network, Inc. is a non profit volunteer organization that offers support and information to families of children with ADD, adults with ADD and professionals through a network of AD-IN chapters. AD-IN was founded in 1988 by several parent support group leaders on the premise of parents helping parents deal with their children with ADD. This network has parent and adult support group chapters throughout the country. AD-IN is a community resource for information on training programs and speakers for those who work with individuals with ADD. This organization also presents conferences and workshops for parents and professionals on current issues, research and treatments for ADD and makes an annual, post-secondary scholarship award. Funding for the activities is derived from conference proceeds, grants from foundations and corporations, donations and contributions.

Contact: 475 Hillside Avenue, Needham, MA 02194 Ph: 781-455-9895
Fax. 781-444-5466 Web: www.addinfonetwork.com Email: adin@gis.net

Children and Adults with Attention Deficit Disorders (CHADD)

CH.A.D.D. has four primary objectives: (1) to maintain a support network for parents who have children with ADD and adults with ADD; (2) to provide a forum for continuing education of parents, professionals, and adults with ADD about the disability; (3) to be a community resource for information about ADD; and (4) to make the best educational experiences available to children with ADD so that their specific difficulties will be recognized and appropriately managed within educational settings. Their website has fact sheets, documents, a newsletter covering topics related to ADD, books to order, and local chapters around the nation.

Contact: 8181 Professional Place, Suite 201, Landover, MD 20785
Phone: 301-306-7070 http://www.chadd.org/

The National Attention Deficit Disorder Association

The National Attention Deficit Disorder Association is a growing non-profit organization that is mostly staffed by volunteers. The organization is built around the needs of people with ADD & ADHD and those who love, live, teach, and counsel them. Their foundation is based on their service to members , public and proffesional community.

Contact: 1070 Rosewood, Suite A, Ann Arbor, MI 48104 Ph: 313/769-6690 or
800/487-2282 FAX: 440-350-0223 E-MAIL: NatlADDA@aol.com
Website: http://www.add.org/

National Information Center for Children and Youth with Disabilities (NICHCY)

NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families,educators, and other professionals. Our special focus is children and youth(birth to age 22). It has a Spanish translation to help facilitate one's understanding, and makes referrels to specific disabilities, early intervention, family issues to education rights and much more.

Contact: P.O. Box 1492, Washington, DC 20013
Phone: 1-800-999-5599 Fax: (703) 893-1741
E-mail: nichcy@capcon.net.internet Website: http://www.nichcy.org/

Contents of Section III B:

Conduct and Behavior Problems

Overview

1. Developmental Variations

2. Problems

3. Disorders

4. Interventions

    - Accommodations
    - Behavior Management and Self Instruction
    - Empirically Supported Treatments
    - Medication

5. A Few References and Other Sources of Information

Overview

In this section, the range of conduct and behavior problems are described using a government fact sheet and the classification scheme from the American Pediatric Association.

Differences in intervention needed are discussed with respect to variations in the degree of problem manifested and include exploration of environmental accommodations, behavioral strategies, and medication.

For those readers ready to go beyond this introductory presentation, we also provide a set of references for further study and, as additional resources, agencies and websites are listed that focus on these concerns.

CARING FOR EVERY CHILD'S MENTAL HEALTH
communities together

FACT SHEET

Conduct Disorder in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) — see contact information below.

What Is Conduct Disorder?

Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Because of the impact conduct disorder has on the child and his or her family, neighbors, and adjustment at school, conduct disorder is known as a "disruptive behavior disorder."

Another disruptive disorder, called oppositional defiant disorder, often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer. Oppositional defiant disorder can start in the preschool years, whereas conduct disorder generally appears when children are somewhat older. Oppositional defiant disorder is not diagnosed if conduct disorder is present.

What Are the Signs of Conduct Disorder?

Some symptoms of conduct disorder include:

- aggressive behavior that harms or threatens to harm other people or animals;
- destructive behavior that damages or destroys property;
- lying or theft; and
- skipping school or other serious violations of rules.

Children with oppositional defiant disorder or conduct disorder may have other problems as well, including:

- hyperactivity;
- anxiety;
- depression;
- academic difficulties; and
- problems with peer relationships.

How Common is Conduct Disorder?

As many as 1 in 10 children and adolescents may have conduct disorder.* Most children and adolescents with conduct disorder do not have lifelong patterns of conduct problems and antisocial behavior.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

**This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for this disorder. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.*

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301.443.2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1800.789.2647 ~~• FAX 302.650.4012~~
FAX 301.984.8796 • TTY 301.443.9006 • CMHS Electronic Bulletin Board 1800.790.264

SAMHSA

Who Is at Risk?

Years of research show that the most troubling cases of conduct disorder begin in early childhood, often by the preschool years. In fact, some infants who are especially "fussy" are at risk for developing conduct disorder. Other factors that may make a child more likely to develop conduct disorder include:

- inconsistent rules and harsh discipline;
- lack of supervision or guidance;
- frequent change in caregivers;
- poverty;
- neglect or abuse; and
- a delinquent peer group.

In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

What Help Is Available for Families?

Conduct disorder is one of the most difficult behavior disorders of childhood and adolescence to treat successfully. However, young people with conduct disorder often benefit from a range of services, which might include:

- parent training on how to handle their child's or adolescent's behavior;
- family therapy;
- training in problem-solving skills for children or adolescents; and
- community-based services that focus on the young person within the context of family and community influences.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

What Can Parents Do?

Antisocial behavior in children and adolescents is very hard to change after it has become ingrained. Therefore, the earlier the problem is identified and treated, the better. Some recent studies have focused on promising ways to prevent conduct disorder among children and adolescents who are at risk for developing the disorder. Most children or adolescents with conduct disorder are probably reacting to events and situations in their lives. More research is needed to determine if biology is a factor in conduct disorder.

Parents should:

- Pay careful attention when a child or adolescent shows signs of oppositional defiant disorder or conduct disorder and try to understand the reasons behind it. Then parents can try to improve the situation or their own reactions.
- Talk with a mental health or social service professional, such as a teacher, counselor, psychiatrist, or psychologist specializing in childhood and adolescent disorders (if parents cannot reduce their child's or adolescent's antisocial behavior on their own).
- Get accurate information from libraries, hotlines, or other sources.
- Talk to other families in their community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available—for free publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006; http://www.mentalhealth.org/

1. Developmental Variations: Behaviors that are Within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Negative Emotional Behavior Variation

Infants and preschool children typically display negative emotional behaviors when frustrated or irritable. The severity of the behaviors varies depending on temperament. The degree of difficulty produced by these behaviors depends, in part, on the skill and understanding of the caregivers.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant typically cries in response to any frustration, such as hunger or fatigue, or cries for no obvious reason, especially in late afternoon, evening, and nighttime hours.

Early Childhood
The child frequently cries and whines, especially when hungry or tired, is easily frustrated, frequently displays anger by hitting and biting, and has temper tantrums when not given his or her way.

Middle Childhood
The child has temper tantrums, although usually reduced in degree and frequency, and pounds his or her fists or screams when frustrated.

Adolescence
The adolescent may hit objects or slam doors when frustrated and will occasionally curse or scream when angered.

SPECIAL INFORMATION

These negative emotional behaviors are associated with temperamental traits, particularly low adaptability, high intensity, and negative mood (...). These behaviors decrease drastically with development, especially as language develops. These behaviors are also especially responsive to discipline.

Environmental factors, especially depression in the parent (...), are associated with negative emotional behaviors in the child. However, these behaviors are more transient than those seen in adjustment disorder (...).

These behaviors increase in situations of environmental stress such as child neglect or physical/sexual abuse (...), but again the behaviors are more transient than those seen in adjustment disorder (...).

As children grow older, their negative emotions and behaviors come under their control. However, outbursts of negative emotional behaviors including temper tantrums are common in early adolescence when adolescents experience frustration in the normal developmental process of separating from their nuclear family and also experience a normal increase in emotional reactiveness. However, a decrease in negative emotional behaviors is associated with normal development in middle to late adolescence.

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

BEST COPY AVAILABLE

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Oppositionality

Mild opposition with mild negative impact is a normal developmental variation. Mild opposition may occur several times a day for a short period. Mild negative impact occurs when no one is hurt, no property is damaged, and parents do not significantly a tor their plans.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant sometimes flails, pushes away, shakes head, gestures refusal, and dawdles. These behaviors may not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress, e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of family member, change in caregivers.

Early Childhood
The child's negative behavior includes saying "now as well as all of the above behaviors but with increased sophistication and purposefulness. The child engages in brief arguments, uses bad language, purposely does the opposite of what is asked, and procrastinates.

Middle Childhood
The child's oppositional behaviors include all of the above behaviors, elaborately defying doing chores, making up excuses, using bad language, displaying negative attitudes, and using gestures that indicate refusal.

Adolescence
The adolescent's oppositional behaviors include engaging in more abstract verbal arguments, demanding reasons for requests, and often giving excuses.

SPECIAL INFORMATION

Oppositional behavior occurs in common situations such as getting dressed, picking up toys, during meals, or at bedtime. In early child-hood, these situations broaden to include preschool and home life. In middle childhood, an increase in school-related situations occurs. In adolescence, independence-related issues become important.

DEVELOPMENTAL VARIATIONS

Aggressive/Oppositional Variation

Aggression

In order to assert a growing sense of self nearly all children display some amount of aggression, particularly during periods of rapid developmental transition. Aggression tends to decline normatively with development. Aggression is more common in younger children, who lack self-regulatory skills, than in older children, who internalize familial and societal standards and learn to use verbal mediation to delay gratification. Children may shift normatively to verbal opposition with development. Mild aggression may occur several times per week, with minimal negative impact.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant's aggressive behaviors include crying, refusing to be nurtured, kicking, and biting, but are usually not persistent.

Early Childhood
The child's aggressive behaviors include some grabbing toys, hating siblings and others, kicking, and being verbally abusive to others, but usually responds to parental reprimand.

Middle Childhood
The child's aggressive behaviors include some engaging in all of the above behaviors, with more purposefulness, getting even for perceived injustice, inflicting pain on others, using profane language, and bullying and hitting peers. The behaviors are intermittent and there is usually provocation.

Adolescence
The adolescent exhibits overt physical aggression less frequently, curses, mouths off, and argues, usually with provocation.

SPECIAL INFORMATION

In middle childhood, more aggression and self-defense occur at school and with peers. During adolescence, aggressive and oppositional behaviors blend together in many cases.

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*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Negative Emotional Behavior Problem

Negative emotional behaviors that increase (rather than decrease) in intensity, despite appropriate caregiver management, and that begin to interfere with child-adult or peer interactions may be a problem. These behaviors also constitute a problem when combined with other behaviors such as hyperactivity/impulsivity (see Hyperactive/ Impulsive Behaviors cluster ...), aggression (see Aggressive/ Oppositional Behavior cluster, ...), and/or depression (see Sadness and Related Symptoms cluster, ...). However, the severity and frequency of these behaviors do not meet the criteria for disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant flails, pushes away, shakes head, gestures refusal, and dawdles. These actions should not be considered aggressive intentions, but the only way the infant can show frustration or a need for control in response to stress--e.g., separation from parents, intrusive interactions (physical or sexual), overstimulation, loss of a family member, or change in caregivers.

Early Childhood
The child repeatedly, despite appropriate limit setting and proper discipline, has intermittent temper tantrums. These behaviors result in caregiver frustration and can affect interactions with peers.

Middle Childhood
The child has frequent and/or intense responses to frustrations, such as losing in games or not getting his or her way. Negative behaviors begin to affect interaction with peers.

Adolescence
The adolescent has frequent and/or intense reactions to being denied requests and may respond inappropriately to the normal teasing behavior of others. The adolescent is easily frustrated, and the behaviors associated with the frustration interfere with friendships or the completion of age-appropriate tasks.

SPECIAL INFORMATION

Intense crying frustrates caregivers. The typical response of caregivers must be assessed in order to evaluate the degree of the problem.

The presence of skill deficits as a source of frustration must be considered (e.g., the clumsy child who does not succeed in games in games in early childhood or in sports in later childhood and adolescence, or the child with a learning disability (...).

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

PROBLEM

Aggressive/Oppositional Problem

Oppositionality

The child will display some of the symptoms listed for oppositional defiant disorder (...). The frequency of the opposition occurs enough to be bothersome to parents or supervising adults, but not often enough to be considered a disorder.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant screams a lot, runs away from parents a lot, and ignores requests.

Early Childhood
The child ignores requests frequently enough to be a problem, dawdles frequently enough to be a problem, argues back while doing chores, throws tantrums when asked to do some things, messes up the house on purpose, has a negative attitude many days, and runs away from parents on several occasions.

Middle Childhood
The child intermittently tries to annoy others such as turning up the radio on purpose, making up excuses, begins to ask for reasons why when given commands, and argues for longer times. These behaviors occur frequently enough to be bothersome to the family.

Adolescence
The adolescent argues back often, frequently has a negative attitude, sometimes makes obscene gestures, and argues and procrastinates in more intense and sophisticated ways.

SPECIAL INFORMATION

All children occasionally defy adult requests for compliance, particularly the requests of their parents. More opposition is directed toward mothers than fathers. Boys display opposition more often than girls and their opposition tends to be expressed by behaviors that are more motor oriented. The most intense opposition occurs at the apex of puberty for boys and the onset of menarche for girls.

PROBLEM

Aggressive/Oppositional Problem

Aggression

When levels of aggression and hostility interfere with family routines, begin to engender negative responses from peers or teachers, and/or cause disruption at school, problematic status is evident. The negative impact is moderate. People change routines; property begins to be more seriously damaged. The child will display some of the symptoms listed* for conduct disorder (...) but not enough to warrant the diagnosis of the disorder. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
The infant bites, kicks, cries, and pulls hair fairly frequently.

Early Childhood
The child frequently grabs others' toys, shouts, hits or punches siblings and others, and is verbally abusive.

Middle Childhood
The child gets into fights intermittently in school or in the neighborhood, swears or uses bad language sometimes in inappropriate settings, hits or otherwise hurts self when angry or frustrated.

Adolescence
The adolescent intermittently hits others, uses bad language, is verbally abusive, may display some inappropriate suggestive sexual behaviors.

SPECIAL INFORMATION

Problem levels of aggressive behavior may run in families. When marked aggression is present, the assessor must examine the family system, the types of behaviors modeled, and the possibility of abusive interactions.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDERS

Conduct Disorder Childhood Onset

Conduct Disorder Adolescent Onset

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Onset may occur as early as age 5 to 6 years, but is usually in late childhood or early adolescence. The behaviors harm others and break societal rules including stealing, fighting, destroying property, lying, truancy, and running away from home.

(see DSM-IV criteria ...)

Adjustment Disorder With Disturbance of Conduct

(see DSM-IV criteria ...)

Disruptive Behavior Disorder, NOS

(see DSM-I V criteria ...)

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

COMMON DEVELOPMENT PRESENTATIONS

Infancy
It is not possible to make the diagnosis.

Early Childhood
Symptoms are rarely of such a quality or intensity to be able to diagnose the disorder.

Middle Childhood
The child often may exhibit some of the following behaviors: lies, steals, fights with peers with and without weapons, is cruel to people or animals, may display some inappropriate sexual activity, bullies, engages in destructive acts, violates rules, acts deceitful, is truant from school, and has academic difficulties.

Adolescence
The adolescent displays delinquent, aggressive behavior, harms people and property more often than in middle childhood, exhibits deviant sexual behavior, uses illegal drugs, is suspended/expelled from school, has difficulties with the law, acts reckless, runs away from home, is destructive, violates rules, has problems adjusting at work, and has academic difficulties.

SPECIAL INFORMATION

The best predictor of aggression that will reach the level of a disorder is a diversity of antisocial behaviors exhibited at an early age; clinicians should be alert to this factor. Oppositional defiant disorder usually becomes evident before age 8 years and usually not later than early adolescence. Oppositional defiant disorder is more prevalent in males than in females before puberty, but rates are probably equal after puberty. The occurrence of the following negative environmental factors may increase the likelihood, severity, and negative prognosis of conduct disorder: parental rejection and neglect (...), inconsistent management with harsh discipline, physical or sexual child abuse (...), lack of supervision, early institutional living (...), frequent changes of caregivers (...), and association with delinquent peer group. Suicidal ideation, suicide attempts, and completed suicide occur at a higher than expected rate (see Suicidal Thoughts or Behaviors cluster). If the criteria are met for both oppositional defiant disorder and conduct disorder, only code conduct disorder.

DISORDERS

Oppositional Defiant Disorder

Hostile, defiant behavior towards others of at least 6 months duration that is developmentally inappropriate.

☐ often loses temper
☐ often argues with adults
☐ often actively defies or refuses to comply with adults' requests or rules
☐ often deliberately annoys people
☐ often blames others for his or her mistakes or misbehavior
☐ is often touchy or easily annoyed by others
☐ is open angry and resentful
☐ is often spiteful or vindictive

(see DSM-IV Criteria...)

COMMON DEVELOPMENT PRESENTATIONS

Infancy
It is not possible to make the diagnosis.

Early Childhood
The child is extremely defiant, refuses to do as asked, mouths off, throws tantrums.

Middle Childhood
The child is very rebellious, refusing to comply with reasonable requests, argues often, and annoys other people on purpose.

Adolescence The adolescent is frequently rebellious, has severe arguments, follows parents around while arguing, is defiant, has negative attitudes, is unwilling to compromise, and may precociously use alcohol, tobacco, or illicit drugs.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

4. Interventions

On the following pages are discussions of

- **Accomodations to Reduce Conduct and Behavior Problems**
- **Behavior Management and Self Instruction**
- **Empirically Supported Treatments for Conduct and Behavior Problems**
- **Medications Used to Treat Conduct and Behavior Problems**

Intervention:

Accommodations to Reduce Conduct and Behavior Problems

From the newsletter of the *Center for Mental Health in Schools* of UCLA

Behavior Problems: What's a School to Do?

In their effort to deal with deviant and devious behavior and create safe environments, schools increasingly have adopted social control practices. These include some *discipline* and *classroom management* practices that analysts see as "blaming the victim" and modeling behavior that fosters rather than counters development of negative values.

To move schools beyond overreliance on punishment and social control strategies, there is ongoing advocacy for social skills *training* and new agendas for *emotional "intelligence" training* and *character education*. Relatedly, there are calls for greater home involvement, with emphasis on enhanced parent responsibility for their children's behavior and learning. More comprehensively, some reformers want to transform schools through creation of an atmosphere of "caring," "cooperative learning," and a "sense of community." Such advocates usually argue for schools that are holistically-oriented and family-centered. They want curricula to enhance values and character, including responsibility (social and moral), integrity, self-regulation (self-discipline), and a work ethic and also want schools to foster self-esteem, diverse talents, and emotional well-being.

Discipline

Misbehavior disrupts; it may be hurtful; it may disinhibit others. When a student misbehaves, a natural reaction is to want that youngster to experience and other students to see the consequences of misbehaving. One hope is that public awareness of consequences will deter subsequent problems. As a result, the primary intervention focus in schools usually is on *discipline* -- sometimes embedded in the broader concept of *classroom management*. More broadly, however, as outlined on p. 2, interventions for misbehavior can be conceived in terms of:

- efforts to prevent and anticipate misbehavior
- actions to be taken during misbehavior
- steps to be taken afterwards.

From a prevention viewpoint, there is widespread awareness that program improvements can reduce learning and behavior problems significantly. It also is recognized that the application of consequences is an insufficient step in preventing future misbehavior.

For youngsters seen as having emotional and behavioral disorders, disciplinary practices tend to be described as strategies to modify deviant behavior. And, they usually are seen as only one facet of a broad intervention agenda designed to treat the youngster's disorder. It should be noted, however, that for many students diagnosed as having disabilities the school's (and society's) socialization agenda often is in conflict with providing the type of helping interventions such youngsters require. This is seen especially in the controversies over use of corporal punishment, suspension, and exclusion from school. Clearly, such practices, as well as other value-laden interventions, raise a host of political, legal, and ethical concerns.

Unfortunately, too many school personnel see punishment as the only recourse in dealing with a student's misbehavior. They use the most potent negative consequences available to them in a desperate effort to control an individual and make it clear to others that acting in such a fashion is not tolerated. Essentially, short of suspending the individual from school, such punishment takes the form of a decision to do something to the student that he or she does not want done. In addition, a demand for future compliance usually is made, along with threats of harsher punishment if compliance is not forthcoming. And the discipline may be administered in ways that suggest the student is seen as an undesirable person. As students get older, suspension increasingly comes into play. Indeed, suspension remains one of the most common disciplinary responses for the transgressions of secondary students.

Intervention Focus in Dealing with Misbehavior

I. Preventing Misbehavior

A. Expand Social Programs
  1. Increase economic opportunity for low income groups
  2. Augment health and safety prevention and maintenance (encompassing parent education and direct child services)
  3. Extend quality day care and early education

B. Improve Schooling
  1. Personalize classroom instruction (e.g., accommodating a wide range of motivational and developmental differences)
  2. Provide status opportunities for nonpopular students (e.g., special roles as assistants and tutors)
  3. Identify and remedy skill deficiencies early

C. Follow-up All Occurrences of Misbehavior to Remedy Causes
  1. Identify underlying motivation for misbehavior
  2. For unintentional misbehavior, strengthen coping skills (e.g., social skills, problem solving strategies)
  3. If misbehavior is intentional but reactive, work to eliminate conditions that produce reactions (e.g., conditions that make the student feel incompetent, controlled, or unrelated to significant others)
  4. For proactive misbehavior, offer appropriate and attractive alternative ways the student can pursue a sense of competence, control, and relatedness
  5. Equip the individual with acceptable steps to take instead of misbehaving (e.g., options to withdraw from a situation or to try relaxation techniques)
  6. Enhance the individual's motivation and skills for overcoming behavior problems (including altering negative attitudes toward school)

II. Anticipating Misbehavior

A. Personalize Classroom Structure for High Risk Students
  1. Identify underlying motivation for misbehavior
  2. Design curricula to consist primarily of activities that are a good match with the identified individual's intrinsic motivation and developmental capability
  3. Provide extra support and direction so the identified individual can cope with difficult situations (including steps that can be taken instead of misbehaving)

B. Develop Consequences for Misbehavior that are Perceived by Students as Logical (i.e., that are perceived by the student as reasonable fair, and nondenigrating reactions which do not reduce one's sense of autonomy)

III. During Misbehavior

A. Try to base response on understanding of underlying motivation (if uncertain, start with assumption the misbehavior is unintentional)

B. Reestablish a calm and safe atmosphere
  1. Use understanding of student's underlying motivation for misbehaving to clarify what occurred (if feasible, involve participants in discussion of events)
  2. Validate each participant's perspective and feelings
  3. Indicate how the matter will be resolved emphasizing use of previously agreed upon logical consequences that have been personalized in keeping with understanding of underlying motivation
  4. If the misbehavior continues, revert to a firm but nonauthoritarian statement indicating it must stop or else the student will have to be suspended
  5. As a last resort use crises back-up resources
     a. If appropriate, ask student's classroom friends to help
     b. Call for help from identified back-up personnel
  6. Throughout the process, keep others calm by dealing with the situation with a calm and protective demeanor

IV. After Misbehavior

A. Implement Discipline -- Logical Consequences/ Punishment
  1. Objectives in using consequences
     a. Deprive student of something s/he wants
     b. Make student experience something s/he doesn't want
  2. Forms of consequences
     a. Removal/deprivation (e.g., loss of privileges, removal from activity)
     b. Reprimands (e.g., public censure)
     c. Reparations (e.g., of damaged or stolen property)
     d. Recantations (e.g., apologies, plans for avoiding future problems)

B. Discuss the Problem with Parents
  1. Explain how they can avoid exacerbating the problem
  2. Mobilize them to work preventively with school

C. Work Toward Prevention of Further Occurrences (see I & II)

As with many emergency procedures, the benefits of using punishment may be offset by many negative consequences. These include increased negative attitudes toward school and school personnel which often lead to behavior problems, anti-social acts, and various mental health problems. Disciplinary procedures also are associated with dropping out of school. It is not surprising, then, that some concerned professionals refer to extreme disciplinary practices as "pushout" strategies.

(Relatedly, a large literature points to the negative impact of various forms of parental discipline on internalization of values and of early harsh discipline on child aggression and formation of a maladaptive social information processing style. And a significant correlation has been found between corporal punishment of adolescents and depression, suicide, alcohol abuse, and wife-beating.)

Logical Consequences

Guidelines for managing misbehavior usually stress that discipline should be reasonable, fair, and nondenigrating. Motivation theory stresses that "positive, best-practice approaches" are disciplinary acts recipients experience as legitimate reactions that neither denigrate one's sense of worth nor reduce one's sense of autonomy. To these ends, discussions of classroom management practices usually emphasize establishing and administering logical consequences. This idea plays out best in situations where there are naturally-occurring consequences (e.g., if you touch a hot stove, you get burned).

In classrooms, there may be little ambiguity about the rules; unfortunately, the same often cannot be said about "logical" penalties. Even when the consequence for a particular rule infraction has been specified ahead of time, its logic may be more in the mind of the teacher than in the eye of the students. In the recipient's view, any act of discipline may be experienced as punitive -- unreasonable, unfair, denigrating, disempowering.

Basically, consequences involve depriving students of things they want and/or making them experience something they don't want. Consequences take the form of (a) removal/deprivation (e.g., loss of privileges, removal from an activity), (b) reprimands (e.g., public censure), (c) reparations (e.g., to compensate for losses caused by misbehavior), and (d) recantations (e.g., apologies, plans for avoiding future problems).

Defining and Categorizing Discipline Practices

Two mandates capture much of current practice:

(a) schools must teach self-discipline to students;
(b) teachers must learn to use disciplinary practices effectively to deal with misbehavior.

Knoff (1987) offers three definitions of discipline as applied in schools: "(a) ... punitive intervention; (b) a means of suppressing or eliminating inappropriate behavior, of teaching or reinforcing appropriate behavior, and of redirecting potentially inappropriate behavior toward acceptable ends; and (c) ..a process of self-control whereby the (potentially) misbehaving student applies techniques that interrupt inappropriate behavior, and that replace it with acceptable behavior". In contrast to the first definition which specifies discipline as punishment, Knoff sees the other two as nonpunitive or as he calls them "positive, best-practices approaches."

Hyman, Flannagan, & Smith (1982) categorize models shaping disciplinary practices into 5 groups:

- psychodynamic-interpersonal models
- behavioral models
- sociological models
- eclectic-ecological models
- human-potential models

Wolfgang & Glickman (1986) group disciplinary practices in terms of a process-oriented framework:

- relationship-listening models (e.g., Gordon's Teacher Effectiveness Training, values clarification approaches, transactional analysis)
- confronting-contracting models (e.g., Dreikurs' approach,, Glasser's Reality Therapy)
- rules/rewards-punishment (e.g., Canter's Assertive Discipline)

Bear (1995) offers 3 categories in terms of the goals of the practice -- with a secondary nod to processes, strategies and techniques used to reach the goals:

- preventive discipline models (e.g., models that stress classroom management, prosocial behavior, moral/character education, social problem solving, peer mediation, affective education and communication models)
- corrective models (e.g., behavior management, Reality Therapy)
- treatment models (e.g., social skills training, aggression replacement training, parent management training, family therapy, behavior therapy).

For instance, teachers commonly deal with acting out behavior by removing a student from an activity. To the teacher, this step (often described as "time out") may be a logical way to stop the student from disrupting others by isolating him or her, or the logic may be that the student needs a cooling off period. It may be reasoned that (a) by misbehaving the student has shown s/he does not deserve the privilege of participating (assuming the student likes the activity) and (b) the loss will lead to improved behavior in order to avoid future deprivation.

Most teachers have little difficulty explaining their reasons for using a consequence. However, if the intent really is to have students perceive consequences as logical and nondebilitating, it seems logical to determine whether the recipient sees the discipline as a legitimate response to misbehavior. Moreover, it is well to recognize the difficulty of administering consequences in a way that minimizes the negative impact on a student's perceptions of self. Although the intent is to stress that it is the misbehavior and its impact that are bad, the student can too easily experience the process as a characterization of her or him as a bad person.

Organized sports such as youth basketball and soccer offer a prototype of an established and accepted set of consequences administered with recipient's perceptions given major consideration. In these arenas, the referee is able to use the rules and related criteria to identify inappropriate acts and apply penalties; moreover, s/he is expected to do so with positive concern for maintaining the youngster's dignity and engendering respect for all.

For discipline to be perceived as a logical consequence, steps must be taken to convey that a response is not a personally motivated act of power (e.g., an authoritarian action) and, indeed, is a rational and socially agreed upon reaction. Also, if the intent is a long-term reduction in future misbehavior, it may be necessary to take time to help students learn right from wrong, to respect others rights, and to accept responsibility.

From a motivational perspective, it is essential that logical consequences are based on understanding of a student's perceptions and are used in ways that minimize negative repercussions. To these ends, motivation theorists suggest (a) establishing a publicly accepted set of consequences to increase the likelihood they are experienced as socially just (e.g., reasonable, firm but fair) and (b) administering such consequences in ways that allow students to maintain a sense of integrity, dignity, and autonomy. These ends are best achieved under conditions where students are "empowered" (e.g., are involved in deciding how to make improvements and avoid future misbehavior and have opportunities for positive involvement and reputation building at school).

Social Skills Training

Suppression of undesired acts does not necessarily lead to desired behavior. It is clear that more is needed than classroom management and disciplinary practices. Is the answer social skills training? After all, poor social skills are identified as a symptom (a correlate) and contributing factor in a wide range of educational, psychosocial, and mental health problems.

Programs to improve social skills and interpersonal problem solving are described as having promise both for prevention and correction. However, reviewers tend to be cautiously optimistic because studies to date have found the range of skills acquired are quite limited and generalizability and maintenance of outcomes are poor. This is the case for training of specific skills (e.g., what to say and do in a specific situation), general strategies (e.g., how to generate a wider range of interpersonal problem-solving options), as well as efforts to develop cognitive-affective orientations (e.g., empathy training). Based on a review of social skills training over the past two decades, Mathur and Rutherford (1996) conclude that individual studies show effectiveness, but outcomes continue to lack generalizability and social validity. (While their focus is on social skills training for students with emotional and behavior disorders, their conclusions hold for most populations.)

For a comprehensive bibliography of articles, chapters, books, and programs on social skills and social competence of children and youth, see Quinn, Mathur, and Rutherford, 1996. Also, see Daniel Goleman's (1995) book on *Emotional Intelligence* which is stimulating growing interest in ways to facilitate social and emotional competence.

Addressing Underlying Motivation

Beyond discipline and skills training is a need to address the roots of misbehavior, especially the underlying motivational bases for such behavior. Consider students who spend most of the day trying to avoid all or part of the instructional program. An intrinsic motivational interpretation of the avoidance behavior of many of these youngsters is that it reflects their perception that school is not a place where they experience a sense of competence, autonomy, and or relatedness to others. Over time, these perceptions develop into strong motivational dispositions and related patterns of misbehavior.

Misbehavior can reflect proactive (approach) or reactive (avoidance) motivation. Noncooperative, disruptive, and aggressive behavior patterns that are proactive tend to be rewarding and satisfying to an individual because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of competence or autonomy). Intentional negative behavior stemming from such approach motivation can be viewed as *pursuit of deviance*.

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. Students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feelings that the situations stimulate (e.g., feelings of incompetence, loss of autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics.

Interventions for such problems begin with major program changes. From a motivational perspective, the aims are to (a) prevent and overcome negative attitudes toward school and learning, (b) enhance motivational readiness for learning and overcoming problems, (c) maintain intrinsic motivation throughout learning and problem solving, and (d) nurture the type of continuing motivation that results in students engaging in activities away from school that foster maintenance, generalization, and expansion of learning and problem solving. Failure to attend to motivational concerns in a comprehensive, normative way results in approaching passive and often hostile students with practices that instigate and exacerbate problems. After making broad programmatic changes to the degree feasible, intervention with a misbehaving student involves remedial steps directed at underlying factors. For instance, with intrinsic motivation in mind, the following assessment questions arise:

- Is the misbehavior unintentional or intentional?
- If it is intentional, is it reactive or proactive?
- If the misbehavior is reactive, is it a reaction to threats to self-determination, competence, or relatedness?
- If it is proactive, are there other interests that might successfully compete with satisfaction derived from deviant behavior?

In general, intrinsic motivational theory suggests that corrective interventions for those misbehaving reactively requires steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. From the theoretical perspective presented above, such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngster's deviant actions. To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, clinicians, parents, or students themselves. (For more on approaching misbehavior from a motivational perspective, see Adelman and Taylor, 1990; 1993; Deci & Ryan, 1985.)

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Intervention:

Behavior Management & Self-Instruction

A popular approach for working with youngsters with behavioral problems in classrooms was summarized in an article entitled Behavior Management in Inclusive Classrooms, which appeared in *Remedial and Special Education, Vol 17* (4), July , 1996, by Stephanie L. Carpenter and Elizabeth McKee-Higgins. The following excerpt from her article captures the idea of this approach.

A primary measure of effectiveness for instructional programs is student academic achievement. However, teachers identify behavioral dimensions as a high priority for the success of students with disabilities and students at risk for school failure in general education classrooms—often as a higher priority than academic skills (Blanton, Blanton, & Cross, 1994; Ellett, 1993; Hanrahan, Goodman, & Rapagna, 1990; Mayer, Mitchell, Clementi, Clement-Robertson, Myatt, & Bullara, 1993). Indeed, students' behaviors during instruction may impact the classroom climate and the extent to which all students are actively engaged in instruction, an indicator of achievement outcomes (Christenson, Ysseldyke, & Thurlow, 1989). A classroom climate characterized by learning and cooperative interactions with groups of students who are motivated, responsive to traditional authority figures and systems (e.g., teachers and schools), and compliant with established rules and routines may be jeopardized by the presence of students who have not learned or adopted behaviors that are compatible with performing within a classroom community of learners. At times the misbehavior of one student or a small group of students seems to spread to other students even when classwide or schoolwide behavioral expectations are established and communicated to students (Smith & Rivera, 1995). When teachers take excessive time to respond to inappropriate student behaviors, valuable instructional momentum and time may be lost. As the diversity of students' characteristics within classrooms increases, the need increases for classroom behavior management systems that are responsive to group and individual student characteristics (Lewis, Chard, & Scott, 1994).

The purpose of this article is twofold. First, proactive behavior management programs are described as an effective means to respond to diverse behavioral characteristics among all students, both those with and without disabilities. Second, one teacher's experiences are described; she incorporated components of a proactive behavior management plan to address both her students' and her own behaviors in order to minimize the negative impact of students' misbehavior on instruction and achievement. An underlying premise is that it is by changing their own behaviors that teachers may have the greatest impact on their students' classroom behaviors.

PROACTIVE BEHAVIOR MANAGEMENT PROGRAMS

Traditional approaches to managing problem behavior have not been responsive to the behavioral and learning characteristics of students with chronic behavior problems (Colvin, F Kameenui, & Sugai, 1993). Despite evidence that effective discipline programs recognize and reward appropriate behavior to promote a positive school climate (Colvin et al., 1993; Mayer et al., 1993), many school or classroom management procedures are reactive, punitive, or control oriented (Colvin et al., 1993; Reitz, 1994). The assumption is that punishment will change behavior in desirable directions. Colvin et al. stated:

> To manage behavior school discipline plans typically rely on reprimands, penalties, loss of privileges, detention, suspension, corporal punishment, and expulsion. By experiencing these reactive consequences it is assumed that students will learn the "right way" of behaving and be motivated sufficiently to comply to the expectations of the school. (p. 364)

Conversely, *effective behavior management programs* that are responsive to individual and group behaviors for classroom or school interactions and participation *are proactive* in nature. Proactive behavior management programs

- Use instructional techniques to develop desired behaviors;
- Promote a positive climate to motivate students;
- Are dynamic and responsive to students' changing behavioral skills; and
- Use collegial interactions to support teachers' use of effective procedures.

Instructional Approach

In an instructional (Colvin et al., 1993) or educative (Reitz, 1994) approach to addressing behavior management, educators view students' participation and interaction behaviors in a way that is similar to their view of students' academic behaviors. The focus is on providing students with structured opportunities to learn and practice desirable behaviors rather than using negative consequences to eliminate undesirable behaviors. The main components of an instructional approach to behavior management include "teaching objectives, explanation of procedures, practice activities, prompts, reinforcement, feedback, and monitoring" (Colvin et al., 1993, p. 366). Colvin and his colleagues developed a model for addressing chronic behavior problems that parallels instruction to remediate chronic academic problems. In this model, teachers (a) identify the functional relationships between behavior and the environment, (b) identify expected or acceptable behaviors, (c) modify the environment so that students can practice expected behaviors in the absence of stimuli that are likely to elicit the inappropriate behavior, (d) reinforce correct responding by using differential reinforcement, and (e) move toward less restrictive or more naturally occurring programming to foster generalization and maintenance of acceptable behaviors.

* * *

Positive Climate

A positive learning climate is one in which the classroom environment is a desirable place to work and to interact with others. For some students, school is not a pleasant place to be because they engage in behaviors that are viewed as undesirable in the classroom environment. When these undesirable behavior patterns are coupled with academic difficulties, a cycle of school failure often emerges that leads many students to stay away from school or ultimately to drop out. Redesigning behavior management programs to create environments that are more desirable places in which to learn should promote greater student motivation to participate in school programs (Dunlap et al., 1993; Mayer et al., 1993). Teachers enhance the learning climate when they recognize the desirable aspects of students' behaviors and structure the classroom environment to facilitate productive work habits and positive interpersonal interactions.

* * *

Reitz (1994) proposed a model for designing comprehensive classroom-based programs for students with emotional and behavioral problems that also included academic and behavioral techniques. Of 10 components presented as essential, five directly or indirectly addressed the creation of a positive class climate:

1. Consistent classroom schedule and structure in which rules, expectations, consequences, and routines are clearly communicated to

followed by the teacher. Students may be involved in developing classroom procedures. The teacher should maintain positive focus by emphasizing desired behaviors and their consequences.

2. High rates of student academic involvement and achievement in which the curriculum (content) and instructional delivery (teacher behavior) focus on high rates of student engagement during instruction and practice.

3. High rates of social reinforcement from teachers to promote the learning of new behaviors. Teachers' use of approval statements is an effective teaching tool.

4. System to ensure high rates of tangible reinforcement in which points or "tokens" are given immediately following the occurrence of a desired student behavior and exchanged later by the student to obtain predetermined privileges, activities, or items.

5. A repertoire of teacher responses to mild disruptive behavior that keeps minor problems from escalating into major ones. Combinations of praise for appropriate behavior and ignoring of inappropriate behavior (e.g., differential reinforcement) are effective in maintaining a focus on the positive.

Teachers promote a positive class climate by structuring the learning environment, emphasizing the desirable aspects of students' behaviors, and engaging in positive interpersonal interactions with all students. Both an instructional orientation and a positive classroom climate are necessary in order for behavioral interventions to be dynamic and responsive to students' changing behavioral skills.

Dynamic and Responsive Interventions

Effective behavior management programs are dynamic processes whereby teachers adjust interventions in response to students' changing behaviors. The premise is that behavior management systems, while maintaining a positive orientation, should impose only as much teacher or outside influence as is necessary to achieve desirable student behaviors and a positive learning climate. Knowing "how much is enough" is a function of experience and knowing students' behavioral characteristics. However, when teachers are faced with classrooms composed of diverse student populations, beginning with more structure paired with ample reinforcement and moving toward less permits teachers the opportunity to set the stage for desirable student behaviors early on.

* * *

Collegial Interactions

Collegial interactions serve two primary purposes during the development and implementation of proactive behavior management systems: (a) support for changes in teacher behaviors and (b) programming consistency. Strong collaborative relationships among school staff facilitates commitment to developing, implementing, and maintaining schoolwide plans for proactive behavior management programs (Colvin et al., 1993; Mayer et al., 1993; Reitz, 1994). Cheney and Harvey (1994) found that teachers desired consultations and feedback so that they could ensure that they were making correct decisions. Indeed, understanding behavioral interventions is a prerequisite for effective implementation (Reimers, Wacker, & Koeppl, 1987). Other teachers, administrators, support personnel, or university faculty may provide ongoing feedback, dialogue, and assistance for teachers as they attempt to adapt their behavior management practices (Dettmer, Thurston, & Dyck, 1993; Idol, Nevin, & Paolucci-Whitcomb, 1994). Reimers et al. reported that teachers who implement behavioral programs proficiently and experience benefits in terms of improved student behaviors rate behavioral interventions as more acceptable and are more likely to use them consistently. Taken together, the research suggests that collegial relationships can influence the success teachers experience with behavior management systems, the consistency of implementation, and ultimately the effectiveness of the program.

* * *

The Problem: Looking Deeper

We used a four-step approach to gather information and arrow the scope of the problem:

1. Determine when behaviors seem to present the greatest barrier to instruction and learning.

2. Determine which behaviors are most problematic and identify alternative behaviors that are desired.

3. Identify teacher, classmate, or environmental variables that precede and/or follow the undesired and desired behaviors.

4. Collect data on student and teacher behaviors.

Synthesizing information about the problem proved helpful in identifying patterns associated with the inappropriate behaviors. Patterns of student behaviors and teacher responses emerged that were useful in designing a comprehensive intervention.

* * *

CONCLUSIONS

For many educators the prospect of educating children with disabilities (and possibly a greater variability of behavioral challenges) in general education classrooms is daunting when (a) the numbers of students in classes are increasing, (b) behavior management procedures are taxed by the range of unacceptable behaviors exhibited by students without disabilities, and (c) supports for using new teaching practices are minimal. From such a perspective, undesirable student behavior is viewed as the *problem* within classrooms and schools. An alternative perspective is to view student behavior as integrally related to the context of the classrooms and schools. In other words, a more fundamental consideration may be the way educators respond to students' behaviors, both desirable and undesirable. The "instructional" methods used, class climate created, individuality supported, and collegiality practiced by educators can significantly influence the behavioral and achievement outcomes for the individual child.

Several lessons emerged as young students with dis-abilities were included in a first-grade classroom. First, when behavior management procedures only marginally (and perhaps negatively) address the behaviors of students without disabilities, including students with disabilities may amplify existing problems. Proactive behavior management programs that are systematically and thoughtfully implemented provide structure and reinforcement that is beneficial for the class as well as the individual child. Second, even though educators may already know about behavior management methods that work, sometimes individual teachers are too close to challenging classroom situations to see clearly what is happening. The collaboration and encouragement of a trusted colleague, or just seeing things through a different lens, can lead to improved outcomes for students and teachers. A final related issue may be the importance of intensive and appropriate intervention at a young age for students, with and without disabilities, who may be at the beginning of a cycle of school failure. Traditionally, the response has been to place such students in separate classes or programs without consideration for how the current environment might be modified and whether modifications are implemented effectively. However, as teachers are encouraged and supported to use known, effective practices in order to be more responsive to all students' learning characteristics, the focus for managing students' behaviors may shift (a) from *where* interventions occur to *what* interventions are effective and (b) from viewing *students as the problem* to viewing *educators as the solution.*■

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AUTHORS' NOTE

The work reported in this article was supported, in part, by Grant No. H029B 10099-92, awarded to Johns Hopkins University from the U.S. Department of Education. However, its content does not necessarily represent the policy of that agency, and no endorsement by the federal government should be inferred.

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Intervention:

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Effective Psychosocial Treatments; of Conduct-Disordered Children and Adolescents: 29 Years, 82 Studies, and 5,272 Kids" by E. V. Brestan and S. M. Eyberg, which appears in the *Journal of Clinical Child Psychology, 27*, 180-189.

Excerpted here are the abstract, an adapted table categorizing relevant research, the authors' conclusions, and the authors' reference list.

Abstract of artilce by E. V. Brestan and S. M. Eyberg, which appears in the *Journal of Clinical Child Psychology, 27*, 180-189.

Reviews psychosocial interventions for child and adolescent conduct problems, including oppositional defiant disorder and conduct disorder, to identify empirically supported treatments. Eighty-two controlled research studies were evaluated using the criteria developed by the Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures. The 82 studies were also examined for specific participant, treatment, and methodological characteristics to describe the treatment literature for child and adolescent conduct problems. Two interventions were identified that met the stringent criteria for well-established treatments: videotape modeling parent training program (Spaccarelli, Cotter, & Penman, 1992; Webster-Stratton, 1984, 1994) and parent-training programs based on Patterson and Gullion 's (1968) manual Living With Children *(Alexander & Parsons, 1973; Bernal, Klinnert, & Schultz, 1980; Wiltz & Patterson, 1974). Twenty of the 82 studies were identified as supporting the efficacy of probably efficacious treatments.*

The excerpts on the following pages highlight the gist of this work.

Treatments Identified as Well Established

Two treatments designed for children with conduct problem behaviors were found to have the strong empirical support required of treatments judged to be well established according to the Chambless criteria. These treatments each address the full constellation of behaviors that characterize conduct-disordered children and, collectively, provide new and current standards of care across the developmental spectrum of childhood. Each of these treatments has several supporting studies among which there are studies sufficient to support the well-established treatment criteria and no studies we found that provide disconfirming data. Studies of these treatments demonstrated superiority to psychological placebo or another treatment.

Parent Training Based on Living With Children

Parent-training programs based on Patterson and Gullion's (1968) manual *Living With Children* are based on operant principles of behavior change and designed to teach parents to monitor targeted deviant behaviors, monitor and reward incompatible behaviors, and ignore or punish deviant behaviors of their child. The treatment has been found superior to control groups in several controlled studies including Alexander and Parsons (1973): Bernal, Klinnert, and Schultz (1980); Firestone, Kelly, and Fike (1980); and Wiltz and Patterson (1974). Treatments using the lessons from *Living With Children* have generally been short-term behavioral parent-training programs and have been compared to standard treatments for children with conduct problems (e.g., psychodynamic therapy, client-centered therapy) in addition to no-treatment control groups. ...

Videotape Modeling Parent Training

Webster-Stratton's parent-training program includes a videotape series of parent-training lessons and is based on principles of parent training originally described by Hanf (1969). Videotape modeling parent training is intended to be administered to parents in groups with therapist-led group discussion of the videotape lessons. The treatment has been tested in several studies, including Spaccarelli, Cotler, and Penman (1992); Webster-Stratton (1984, 1990, 1994); and Webster-Stratton, Kolpacoff, and Hollinsworth (1988), in which it has been compared to wait-list control groups and to alternative parent-training formats. The studies have typically included both boys and girls in the 4- to 8-year-old age range who have been selected for treatment based on either parent referral for behavior problems or diagnostic criteria for ODD or CD.

Parents receiving videotape modeling parent training have rated their children as having fewer problems after treatment than control parents, and these parents have rated themselves as having better attitudes toward their child and greater self-confidence regarding their parenting role. Parents receiving the videotape treatment have also shown better parenting skills than control parents on observational measures in the home, and their children have shown greater reduction in observed deviant behavior.

Treatments Identified as Probably Efficacious

Ten treatments for children or adolescents with conduct problem behaviors were found to have the necessary empirical support required of treatments judged probably efficacious according to the Chambless criteria. These treatments and their supporting studies are listed in Table 2. Among the studies meeting the probably efficacious treatment criteria, there is strong representation of parent-child treatments based on Hanf's (1969) two-stage behavioral treatment model for preschool-age children (Eyberg, Boggs, & Algina, 1995; Hamilton & MacQuiddy, 1984; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991; Peed, Roberts, & Forehand, 1977; Wells & Egan, 1988; Zangwill, 1983), as is Webster-Stratton's well-established treatment using videotape modeling. The delinquency prevention program (Tremblay, Pagani-Kurtz, Masse, Vitaro, & Phil, 1995; Vitaro & Tremblay, 1994) is also designed for preschool-age children.

Treatments for older children with conduct problem behaviors are represented in the probably efficacious treatments as well. Research teams led by Kazdin, studying problem solving skills training (Kazdin, Esveldt-Dawson, French. & Unis, 1987a, 1987b; Kazdin, Siegel, & Bass, 1992), and by Lochman, studying anger coping therapy (Lochman, Burch, Curry, & Lampron. 1984; Lochman, Lampron, Gemmer, & Harris, 1989) have each conducted rigorous evaluations of treatments for school-age children (see Table 2). Finally, four treatments for conduct-disordered adolescents have attained probably efficacious treatment status: anger control/stress inoculation (Feindler, Marriott, & Iwata, 1984; Schlichter & Horan, 1981) assertiveness training (Huey & Rank, 1984), multisystemic therapy (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler et al., 1986). and rational-emotive therapy (Block, 1978).

* * *

Table 2. The Probably Efficacious Treatments and the Studies Supporting Their Efficacy

Treatment	**Supporting Studies**
Anger Control Training With Stress Inoculation	Feindler, Marriott, & Iwata (1984); Schlichter & Horan (1981)
Anger Coping Therapy	Lochman, Burch, Curry, & Lampron (1984); Lochman, Lampron, Gemmer, & Harris (1989)
Assertiveness Training	Huey & Rank (1984)
Delinquency Prevention Program	Tremblay, Pagani-Kunz, Masse, Vitaro, & Phil (1995); Vitaro & Tremblay (I994)
Multisystemic Therapy	Borduin, Mann, Cone, Henggeler, Fucci, Blaskse, & Williams (1995); Henggeler, Rodick, Borduin, Hanson, Watson, & Urey (1986); Henggeler, Melton, & Smith (1992)
Parent-Child Interaction Therapy	Eyberg, Boggs, & Algina (1995); McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk (1991); Zangwill (1983)
Parent Training Program	Peed, Roberts, & Forehand (1977); Wells & Egan (1988)
Problem Solving Skills Training	Kazdin, Esveldt-Dawson, French, & Unis (1987a); Kazdin, Esveldt-Dawson, French, & Unis (1987b); Kazdin, Siegel, & Bass (1992)
Rational-Emotive Therapy	Block (1978)
Time-Out Plus Signal Seat Treatment	Hamilton & MacQuiddy (1984)

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Intervention:

PSYCHOTROPIC MEDICATIONS CATEGORIZED BY CHILD /ADOLESCENT DIAGNOSIS*

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference*.

II. Diagnosis: Conduct Disorder – Medication Types and Treatment Effects

(There continues to be controversy over whether medication is indicated for this diagnosis. However, because it is prescribed widely for such cases, it is included here.)

A. *Anti-psychotics*

Used to treat severe behavioral problems in children marked by combativeness and/or explosive hyperexcitable behavior (out of proportion to immediate provocations). Also used in short-term treatment of children diagnosed with conduct disorders who show excessive motor activity impulsivity, difficulty sustaining attention, aggressiveness, mood lability and poor frustration tolerance.

B. Anti-manic

Used to reduce the frequency and intensity of manic episodes. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, or poor judgement, aggressiveness, and possible hostility.

C. Beta-adenergic antagonists

Although primarily used in controlling hypertension and cardiac problems, beta-adenergic antagonists such as propranolol hydrochloride are used to reduce somatic symptoms of anxiety such as palpitations, tremulousness, perspiration, and blushing. In some studies, propranolol is reported as reducing uncontrolled rage outbursts and/or aggressiveness among children and adolescents (Green, 1995).

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*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitoring of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/

Names: Generic (Commercial)	**Some Side Effects and Related Considerations**
A. Anti-psychotics	
thioridazine hydrochloride [Mellaril, Mellaril-S] chlorpromazine hydrochloride [Thorazine; Thor-Pram]	May manifest sedation, drowsiness, dizziness, fatigue, weight gain, blurred vision, rash, dermatitis, extrapyramidal syndrome (e.g . pseudo-Parkinson, Tardive dyskinesia, hyperactivity), respiratory distress, constipation, photosensitivity. Medication is to be taken with food or a full glass of water or milk. Care to avoid contact with skin because of the danger of contact dermatitis. Gradual discontinuation is recommended. Drowsiness can be reduced with decreased dosages. Youngster is to move slowly from sitting or lying down positions. Care must be taken to minimize exposure to strong sun.
haloperidol [Haldol]	May manifest insomnia, restlessness, fatigue, weight gain, dry mouth, constipation,extrapyamidal reactions (e.g., pseudo-Parkinson, Tardive dyskinesia, dystonia, muscle spasms in neck and back, trembling hands), blurred vision, photosensitivity, decreased sweating leading to overheating, menstrual irreg. Avoid sun and overheating. Discontinue gradually.
B. Anti-manic	
lithium carbonate/citrate [Lithium, Lithane, Lithobid, Lithotabs, Lithonate, Eskalith Cibalith]	Safety and effectiveness have not been established for those under 15 years of age. May manifest tremor, drowsiness, dizziness, nausea, vomiting, fatigue, irritability, clumsiness, slurred speech, diarrhea, increased thirst, excessive weight gain, acne, rash. Serum levels must be monitored carefully because of therapeutic dose is close to toxic level. Care must be taken to maintain normal fluid and salt levels
propranolol hydrochloride [Inderal]	May manifest sleep disturbance, drowsiness, confusion, depression, light headedness, nausea, vomiting, fatigue, dry mouth, heartburn, weight gain, leg fatigue. Administer before meals and bed. Avoid having extremities exposed to cold for long periods. Discontinue gradually over a two week period.

Revisiting Medication for Kids

Psychiatrist Glen Pearson is president of the American Society for Adolescent Psychiatry (ASAP). The following is republished with his permission from the society's newsletter.

It happens several times a week in my practice of community child and adolescent psychiatry: Our society's overwhelming belief in medically controlling our kids' behavior finds expression in ever more Huxleyesque demands on the psychiatrist to prescribe. This week's winners are the school district, the juvenile court, and a religious shelter for homeless families with children. Their respective would-be victims are LaShondra, Trevor, and Jimmy.

Jimmy is a 9 year old boy with a long history of treatment for severe emotional disturbance. He's in a school-based day treatment program and seems to be making terrific progress on self-managing his behavior. This turnaround has occurred just in the past few weeks, following an acute psychiatric hospital stay during which the many psychotropic medications he'd been taking without apparent benefit were tapered and discontinued. He was discharged to the day treatment facility and is receiving case management and therapeutic services at home in the community. Unfortunately, the grandmother with whom he lives has been evicted from her residence, and has applied for assistance to a homeless family program. She and Jimmy are scheduled to be admitted to a shelter program next week, but the shelter has made it a condition of receiving services that Jimmy be on medication

LaShondra is 14. She is in special education classes at her junior high school because of mild mental retardation and emotional disturbance. She bears both physical and psychic scars of early prolonged abuse, and has symptoms of borderline personality pathology and PTSD. She likes school and wants to learn, but keeps getting expelled for behavioral outbursts. The school, too, has made it a condition of her readmittance to classes that she be on medication. LaShondra experiences psychotropic medication as inimical to her emerging adolescent autonomy, and has had negative therapeutic effects during past trials of treatment.

Trevor, at 15, is incarcerated in the Juvenile Detention Center, awaiting a hearing on certification to stand trial as an adult on two charges of capital murder. We have evaluated him for fitness to proceed and determined that he's not mentally ill, but are involved in providing services to Trevor in consultation with the juvenile authorities because he is persistently threatening suicide. We think the best plan is to keep him closely supervised in detention, but the juvenile department is concerned about their liability and petition the court to transfer him to a psychiatric hospital. Two hearings are held on the same day. At the first hearing Trevor is committed to a private facility, on condition that the facility accepts the admission. The facility refuses. At the second hearing, Trevor is committed to the state hospital on condition that the hospital certifies that they can guarantee security.

The hospital can't. The Court then orders that Trevor be involuntarily administered unspecified psychotropic agents by injection.

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids. How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

Since 1980, we've trained a generation or two of psychiatrists in the phenomenological approach to diagnosis. The last three editions of the DSM (III-R, and IV) are determinedly atheoretical and empirical in their approach (the majority of members of the Work Groups on Child and Adolescent Disorders for the last three DSM's have been pediatric psychopharmacology researchers), and I think we have long since abandoned trying to teach residents to think about the meanings of symptoms to patients (and ourselves), about the dynamics of intrapsychic structure and interpersonal process. During the same time, the explosive growth of neuroscience and pharmacology has given us many new tools with which to work (if only we knew how: my friend and teacher Bob Beavers used to say, "if the only tool you have is a hammer, everything looks like a nail to you!").

In short, I think we've unwittingly relinquished our most powerful and proven tool: appropriately affectionate, professionally respectful, intimate personal engagement of the patient in mutual exploration of inner meanings. We're frittering our therapeutic potency away on serial trials of psychotropic drugs, and we're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

The point I'm trying to make is that every sector of today's society contributes to this pressure to prescribe. Parents believe medication will cure, schools believe it, courts believe it, even nonpsychiatric mental health professionals believe it. Well, I don't believe it, and it's been my experience with ASAP that most of our members don't believe it either. And, if not only do we not believe that medicine cures, but also we do believe that we have a more powerful and effective treatment which provides an essential context for medication to be helpful, let's stand up and say so. I look forward to hearing from y'all: agree or disagree.

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* See references in previous excerpted articles

Agencies and Online Resources Related to Conduct and Behavior Problems

Center for the Prevention of School Violence

The Center's Safe Schools Pyramid focuses on the problem of school violence. This draws attention to the seriousness of school violence and act as a resource to turn to for information, program assistance, and research about school violence prevention. .

Contact: 20 Enterprise Street, Suite 2, Raleigh, North Carolina 27607-7375
Phone: 1-800-299-6054 or 919-515-9397 Fax: 919-515-9561
Website: http://www2.ncsu.edu/ncsu/cep/PreViolence/CtrPreSchVio.html

Center for the Study and Prevention of Violence (CSPV)

CSPV works from a multi-disciplinary platform on the subject of violence and facilitates the building of bridges between the research community and the practitioners and policy makers. The CSPV Information House has research literature and resources on the causes and prevention of violence and provides direct information services to the public by offering topical searches on customized databases. CSPV also offers technical assistance for evaluation and development of violence prevention programs, and maintains a basic research component on the causes of violence and the effectiveness of prevention and intervention programs.

Contact: Institute of Behavioral Science, University of Colorado at Boulder
Campus Box 442. Boulder, CO 80309-0442 Phone: (303) 492-8465
FAX: (303) 443-3297 E-mail: cspv@colorado.edu Website: http://www.colorado.edu/cspv/

Institute on Violence and Destructive Behavior

Intention is to empower schools and social service agencies to address violence and destructive behavior, at the point of school entry and beyond, in order to ensure safety and to facilitate the academic achievement and healthy social development of children and youth. Combines community, campus and state efforts to research violence and destructive behavior among children and youth. http://interact.uoregon.edu/ivdb.html

National School Safety Center

Created by presidential directive in 1984 to meet the growing need for additional training and preparation in the area of school crime and violence prevention. Affiliated with Pepperdine University, NSSC is a nonprofit organization whose charge is to promote safe schools -- free of crime and violence -- and to help ensure quality education for all America's children. http://www.nssc1.org

National Youth Gang Center

Purpose is to expand and maintain the body of critical knowledge about youth gangs and effective responses to them. Assists state and local jurisdictions in the collection, analysis, and exchange of information on gang-related demographics, legislation, literature, research, and promising program strategies. Also coordinates activities of the Office of Juvenile Justice & Delinquency Prevention (OJJDP) Youth Gang Consortium -- a group of federal agencies, gang program representatives, and service providers. http://www.iir.com/nygc

Partnerships Against Violence Network

PAVNET Online is a "virtual library" of information about violence and youth-at-risk, representing data from seven different Federal agencies. It is a "one-stop," searchable, information resource to help reduce redundancy in information management and provide clear and comprehensive access to information for States and local communities. http://www.pavent.org

Safe and Drug-Free Schools Programs Office (ED)

The Safe and Drug-Free Schools Program is the Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools. The program supports initiatives to meet the seventh National Education Goal, which states that by the year 2000 all schools will be free of drugs and violence and the unauthorized presence of firearms and alcohol, and offer a disciplined environment conducive to learning. These initiatives are designed to prevent violence in and around schools, strengthen programs that prevent illegal use of substances, involve parents, and are coordinated with related Federal, State and community efforts and resources. http://www.ed.gov/offices/OESE/SDFS/

Social Development Research Group

Research focus on the prevention and treatment of health and behavior problems among young people. Drug abuse, delinquency, risky sexual behavior, violence, and school dropout are among the problems addressed. J. David Hawkins, director, and Richard F. Catalano, associate director, began in 1979 to develop the Social Development Strategy, which provides the theoretical basis for risk- and protective-focused prevention that underlies much of the groups' research. http://weber.u.washington/edu/~sdrg/

Contents of Section III C:

Anxiety Problems

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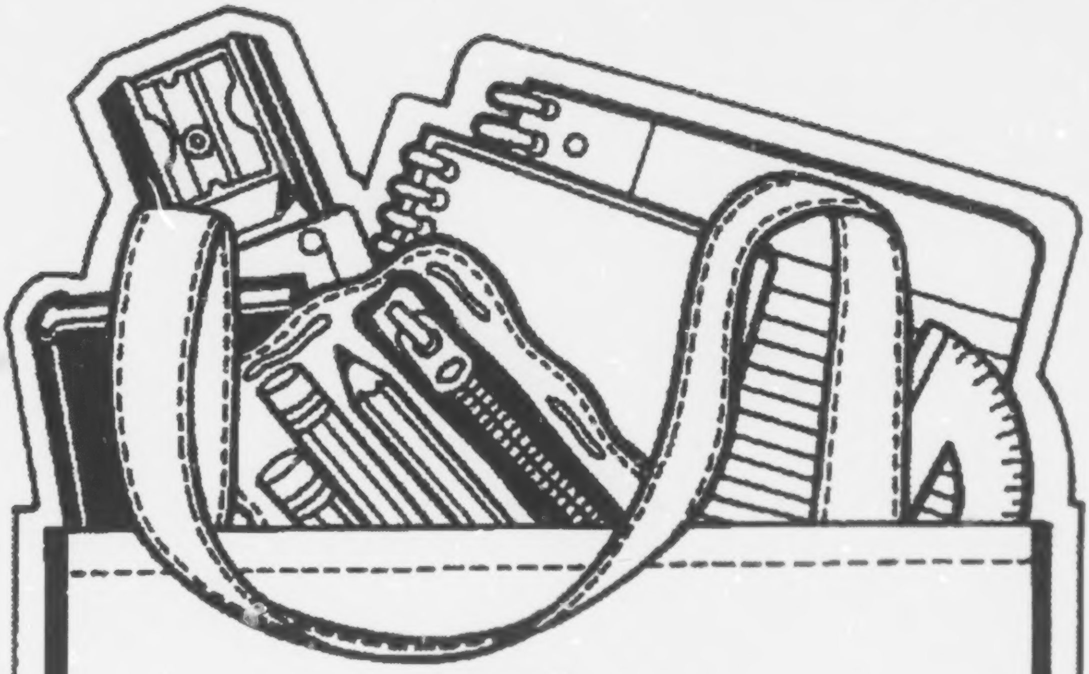

Overview

In providing an introduction to anxiety problems, a government fact sheet is offered and the problems are framed with the classification scheme developed by the American Pediatric Association. The variations in degree of problem are discussed with respect to interventions that range from environmental accommodations to behavioral strategies to medication.

For pursuing further information, a set of references and a list of agencies and websites are included.

CARING FOR EVERY CHILD'S MENTAL HEALTH
communities together

FACT SHEET

Anxiety Disorders in Children and Adolescents

This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) — see contact information below.

What Are Anxiety Disorders?

Young people with an anxiety disorder typically are so afraid, worried, or uneasy that they cannot function normally. Anxiety disorders can be long-lasting and interfere greatly with a child's life. If not treated early, anxiety disorders can lead to:

- missed school days or an inability to finish school;
- impaired relations with peers;
- low self-esteem;
- alcohol or other drug use;
- problems adjusting to work situations; and
- anxiety disorder in adulthood.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

What Are the Signs of Anxiety Disorder?

There are a number of different anxiety disorders that affect children and adolescents. Several are described below.

Generalized Anxiety Disorder. Children and adolescents with this disorder experience extreme, unrealistic worry that does not seem to be related to any recent event. Typically, these young people are very self-conscious, feel tense, have a strong need for reassurance, and complain about stomach aches or other discomforts that don't appear to have any physical basis.

Phobias. A phobia is an unrealistic and excessive fear of some situation or object. Some phobias, called specific phobias, center on animals, storms, water, heights, or situations, such as being in an enclosed space. Children and adolescents with social phobias are terrified of being criticized or judged harshly by others. Because young people with phobias will try to avoid the objects and situations that they fear, the disorder can greatly restrict their lives.

Panic Disorder. Panic disorder is marked by repeated panic attacks without apparent cause. Panic attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The experience is so scary that the young person lives in dread of another attack. He or she may go to great lengths to avoid any situation that seems likely to bring on a panic attack. A child with panic disorder may not want to go to school or be separated from his or her parents.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301 443 2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1800 789 2647 ~~• FAX 302 656 4012~~
FAX 301 984 8796 • TTY 301 443 9006 • CMHS Electronic Bulletin Board 1800 790 2647
SAMHSA

Obsessive-Compulsive Disorder. A child with obsessive-compulsive disorder becomes trapped in a pattern of repetitive thoughts and behaviors. Even though the child may agree that the thoughts or behaviors appear senseless and distressing, the repetitions are very hard to stop. The compulsive behaviors may include repeated hand washing, counting, or arranging and rearranging objects.

Post-Traumatic Stress Disorder. Post-traumatic stress disorder can develop in children or adolescents after they experience a very stressful event. Such events may include physical or sexual abuse; being a victim of or witnessing violence; or being caught in a disaster, such as a bombing or hurricane. Young people with post-traumatic stress disorder experience the event again and again in strong memories, flashbacks, or troublesome thoughts. As a result, the young person may try to avoid anything associated with the trauma. They may also overreact when startled or have difficulty sleeping.

How Common Are Anxiety Disorders?

Anxiety disorders are among the most common mental, emotional, and behavior problems that occur during childhood and adolescence. As many as 1 in 10 young people may have an anxiety disorder.* Among adolescents, more girls than boys are affected. About half of the children and adolescents with anxiety disorders also have a second anxiety disorder or other mental or behavioral disorder, such as depression.

Who Is at Risk?

Researchers have found that a person's basic temperament may play a role in some childhood and adolescent anxiety disorders. For example, some young people tend to be very shy and restrained in unfamiliar situations. This may be a sign that the child or adolescent is at risk for developing an anxiety disorder.

Researchers also suggest watching for signs of anxiety disorders when children are between the ages of 6 and 8. At this age, children grow less afraid of the dark and imaginary creatures and more anxious about school performance and social relationships. High levels of anxiety in a child aged 6 to 8, therefore, may be a warning sign that the child may develop anxiety disorder later. A child's fears may change as a child ages, which complicates research.

Studies suggest that children or adolescents are more likely to have an anxiety disorder if their parents have anxiety disorders. However, the studies do not prove whether the disorders are caused by biology, environment, or both. More studies are needed to clarify whether or not anxiety disorders can be inherited. The Federal Government's National Institute of Mental Health, a part of the National Institutes of Health, is pursuing a wide range of studies on anxiety disorders in children, adolescents, and adults.*

What Help Is Available for a Young Person With an Anxiety Disorder?

Children and adolescents with anxiety disorders can benefit from a variety of treatments and services. After an accurate diagnosis, possible treatments include:

- cognitive-behavioral treatment (where young people learn to deal with fears by modifying the way they think and behave);
- other individual therapy;
- family therapy;
- parent training; and
- medication.

While cognitive-behavioral approaches are effective in treating some anxiety disorders, medications work well with others. Some anxiety disorders benefit from a combination of these treatments. In general, more studies are needed to find which treatments work best for the various types of anxiety disorders.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

**This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for these disorders. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.*

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community.

In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

What Can Parents Do?

If parents or other caregivers notice repeated symptoms of an anxiety disorder in a child or adolescent, they should:

- Talk with the child's doctor. The doctor can help determine whether the symptoms are caused by an anxiety disorder or by some other condition. Then, if needed, the doctor can refer the family to a mental health professional.
- Look for a mental health professional who has training and experience:
    - working with children and adolescents;
    - using cognitive-behavioral or behavior therapy; and
    - prescribing medications for this disorder or, if appropriate, cooperating with a physician who prescribes medications.

The mental health professional should be willing to work closely with the parents as well as with the child or adolescent and his or her school.

- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk to other families in the community.
- Find family network organizations.

It is important for people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available—for free publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006; http://www.mentalhealth.org/

5.30.96

1. Developmental Variation Within the Range of Expected Behaviors for That Age Group

DEVELOPMENTAL VARIATION

Anxious Variation

Fears and worries are experienced that are appropriate for developmental age and do not affect normal development.

Transient anxious responses to stressful events occur in an otherwise healthy child and they do not affect normal development.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Normal fears of noises, heights, and loss of physical support are present at birth. Fear of separation from parent figures and fear of strangers are normal symptoms during the first years of life. The latter peaks at 8 to 9 months. Feeding or sleeping changes are possible in the first year. Transient developmental regressions occur after the first year. Scary dreams may occur.

Early childhood
By age 3 years, children can separate temporarily from a parent with minimal crying or clinging behaviors. Children described as shy or slow to warm up to others may be anxious in new situations. Specific fears of thunder, medical settings, and animals are present.

Middle Childhood
In middle childhood, a child with anxious symptoms may present with motor responses (trembling voice, nail biting, thumb sucking) or physiologic responses (headache, recurrent abdominal pain, unexplained limb pain, vomiting, breathlessness). Normally these should be transient and associated with appropriate stressors. Transient fears may occur after frightening events, such as a scary movie. These should be relieved easily with reassurance.

Adolescence
Adolescents may be shy, avoid usual pursuits, fear separation from friends, and be reluctant to engage in new experiences. Risk-taking behaviors, such as experimentation with drugs or impulsive sexual behavior, may be seen.

SPECIAL INFORMATION

Clinicians should attempt to identify any potential stressful events that may have precipitated the anxiety symptoms (...).

Difficulty falling asleep, frequent night awakenings, tantrums and aggressiveness, and excessive napping may reflect anxiety.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Anxiety Problem

An anxiety problem involves excessive worry or fearfulness that causes significant distress in the child. However, the behaviors are not sufficiently intense to qualify for an anxiety disorder or adjustment disorder with anxious mood.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy and Early Childhood
In infancy and early childhood, anxiety problems usually present with a more prolonged distress at separation or as sleep and feeding difficulties including anxious clinging when not separating.

Middle Childhood
In middle childhood, anxiety may be manifest as sleep problems, fears of animals, natural disasters, and medical care, worries about being the center of attention, sleep-overs, class trips, and the future (see Sadness and Related Symptoms cluster). Anxiety may involve some somatic symptoms such as tachycardia, shortness of breath, sweating, choking, nausea, dryness, and chest pain (...). Environmental stress may be associated with regression (loss of developmental skills), social withdrawal, agitation/hyperactivity, or repetitive reenactment of a traumatic event through play. These symptoms should not be severe enough to warrant the diagnoses of a disorder and should resolve with the alleviation of the stressors.

Adolescence
In adolescence, anxiety may be manifest as sleep problems and fears of medical care and animals. Worries about class performance, participation in sports, and acceptance by peers may be present. Environmental stress may be associated with social withdrawal, boredom (see Sadness and Related Symptoms cluster), aggressiveness, or some risk-taking behavior (e.g., indiscriminate sexual behavior, drug use, or recklessness).

SPECIAL INFORMATION

Anxiety problems have a number of different clinical presentations including persistent worries about multiple areas in the child's life, excessive or unreasonable fear of a specific object or situation, fear of situations in which the child has to perform or be scrutinized by others, excessive worry about separation from parents, or anxiety following a significant, identifiable stressor.

Separation difficulties may be prolonged if inadvertently rewarded by parents and can result in a separation anxiety disorder.

Parental response to the child's distress or anxiety is a key factor in the assessment of anxiety problems. The extent of the child's anxiety may be difficult to assess and the primary care clinicians should err on the side of referral to a mental health clinician if there is uncertainty about the severity of the condition.

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*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

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3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DISORDER

Generalized Anxiety Disorder

This disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a multitude of domains or situations, such as school work, sports, or social performance, and is associated with impaired functioning. The disorder is often associated with somatic and subjective/behavioral symptoms of anxiety (see Special Information).

(see DSM-IV Criteria...)

Social Phobia

This phobia involves a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person recognizes the fear is excessive or un-reasonable. Avoidance of the situation leads to impaired functioning.

(see DSM-IV Criteria ...)

Specific Phobia

Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus provokes an immediate anxiety response. In individuals under 18 years, the duration is at least 6 months. The anxiety associated with the object/situation is not better accounted for by another mental disorder.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely diagnosed in infancy. During the second year of life, fears and distress occurring in situations not ordinarily associated with expected anxiety that is not amenable to traditional soothing and has an irrational quality about it may suggest a disorder.

The fears are, for example, intense or phobic reactions to cartoons or clowns, or excessive fear concerning parts of the house (e.g., attic or basement).

Early Childhood
Rarely diagnosed in this age group. In children, these disorders may be expressed by crying, tantrums, freezing, or clinging, or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults to the extent that family life is disrupted.

Middle Childhood and Adolescence
Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) (...) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions. In addition, an increase in worries and sleep disturbances are present.

SPECIAL INFORMATION

Generalized anxiety disorder has subsumed the *DSM-III-R* diagnosis of overanxious disorder.

Severe apprehension about performance may lead to refusal to attend school. This must be distinguished from other causes of refusal, including realistically aversive conditions at school (e.g., the child is threatened or harassed), learning disabilities (...), separation anxiety disorder (see below), truancy (the child is not anxious about performance or separation), and depression (see Sadness and Related Symptoms cluster). To make these diagnoses in children, there must be evidence of capacity for social relationships with adults. Because of the early onset and chronic course of the disorder, impairment in children tends to take the form of failure to achieve an expected level of functioning rather than a decline from optimal functioning. Children with generalized anxiety disorder may be overly conforming, perfectionists and unsure of themselves and tend to redo tasks because of being zealous in seeking approval and requiring excessive reassurance about their performance and other worries.

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DISORDER

Separation Anxiety Disorder

Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

(see DSM-IV Criteria ...)

Panic Disorder

This disorder involves recurrent unexpected (uncued) panic attacks. Apprehension and anxiety about the attacks or a significant change in behavior related to the attack persists for at least 1 month. A panic attack is a discrete episode of intense fear or discomfort with sudden onset combining the following psychological symptoms— a sense of impending doom, fear of going crazy, and feelings of unreality—with somatic symptoms such as shortness of breath/dyspnea, palpitations/tachycardia, sweating, choking, chest pain, nausea, dizziness, paresthesia.

(see *DSM IV Criteria* ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not relevant at disorder level.

Early and Middle Childhood
When separated from attachment figures, children may exhibit social withdrawal, apathy, sadness, difficulty concentrating on work or play. They may have fears of animals, monsters, the dark, muggers, kidnappers, burglars, car accidents; concerns about death and dying are common. When alone, young children may report unusual perceptual experiences (e.g., seeing people peering into their room).

Adolescence
Adolescents with this disorder may deny feeling anxiety about separation; however, it may be reflected in their limited independent activity and reluctance to leave home.

Infancy
Not relevant at disorder level.

Early Childhood
In children, these disorders may be expressed by crying, tantrums freezing, clinging, or staying close to a familiar person during a panic attack.

Middle Childhood
Panic attacks may be manifested by symptoms such as tachycardia shortness of breath, spreading chest pain, and extreme tension.

Adolescence
The symptoms are similar to those seen in an adult, such as the sense of impending doom, fear of going crazy, feelings of unreality and somatic symptoms such as shortness of breath, palpitations, sweating, choking, and chest pain.

SPECIAL INFORMATION

Separation anxiety disorder must be beyond what is expected for the child's developmental level to be coded as a disorder. In infancy, consider a developmental variation or anxiety problem rather than separation anxiety disorder. Worry about separation may take the form of worry about the health and safety of self or parents.

Separation anxiety disorder may begin as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Use early onset specifier if the onset of disorder is before 6 years. Children with separation anxiety disorder are often described as demanding, intrusive, and in need of constant attention which may lead to parental frustration.

Separation anxiety disorder is a common cause of refusal to attend school. Parental difficulty in separating from the child may contribute to the clinical problem (...). A break down in the marital relationship (marital discord) and one parent's over-involvement with the child is often seen (...). Children with serious current or past medical problems (...) may be overprotected by parents and at greater risk for separation anxiety disorder. Parental illness and death may also increase risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

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SPECIAL INFORMATION, CONTINUED

Although panic attacks can be overwhelming, the social impairment in panic disorders is the result of secondary avoidance, rather than the attacks themselves. Panic attacks or panic symptoms can occur in a variety of anxiety problems or disorders, including specific phobia, social phobia, separation anxiety disorder, and posttraumatic stress disorder. Panic attacks in these disorders, however, are situationally bound, or cued; that is, they are triggered by specific contexts or environmental stimuli. Unexpected or uncued panic attacks must occur for a diagnosis of panic disorder. Major depressive disorder frequently (50% to 65%) occurs in individuals with panic disorder.

DISORDER

Posttraumatic Stress Disorder (PTSD)

PTSD occurs following exposure to an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The child or adolescent has symptoms in each of the following three areas for more than 1 month, causing significant distress or impairment of functioning: (1) persistent reexperiencing of the trauma, (2) avoidance of stimuli associated with the trauma and diminished general responsiveness, and (3) increased arousal or hyper vigilance. In infancy, a numbing of responsiveness may also occur.

(see DSM-IV Criteria ...)

Acute Stress Disorder

(see *DSM-IV* Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely diagnosed but may take the form of extra fears or aggressive behaviors in response to stress.

Early Childhood, Middle Childhood, Adolescence
In children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Reliving of the trauma may occur through repetitive play. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

SPECIAL INFORMATION

PTSD follows exposure to acute or chronic stressors that involve actual or threatened death or serious injury to the child or others. The child must have reacted with intense fear, disorganized or agitated behavior, or helplessness. Stressors may be acute or chronic, single or multiple.

PTSD may be chronic and associated with significant morbidity. Symptoms of repetitive trauma re-enacting play and a sense of a foreshortened future may persist after distress is no longer present.

PTSD must be distinguished from normal bereavement. Bereavement is characterized by sadness and recurrent thoughts, but not by persistent impairment of functioning (see Sadness and Related Symptoms cluster).

Consider sexual abuse/rape (...). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents and teachers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult.

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[*] Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

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DISORDER

Obsessive-Compulsive Disorder

The obsessions and/or compulsions interfere with functioning, cause marked distress, or occupy more than 1 hour a day.

(see DSM-IV Criteria...)

Anxiety Disorder, Not otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely presents at this age.

Early Childhood
The child evidences a higher degree of compulsive and ritualistic behavior, from holding onto certain objects, watching certain videotapes, or lining up toys in certain sequences. These rigidities are less responsive to soothing and interaction than at the problem level. When these ritualistic behaviors are associated with problems in relating and communicating (see Social Interaction Behaviors cluster).

Middle Childhood and Adolescence

The child presents with obsessions and compulsions such as repetitive hand washing, ordering, checking, counting, repeating words silently, repetitive praying. The obsessions or compulsions interfere with listening or attending in class and frequently grades worsen because the child cannot sit still during tests or lectures.

The child may fear harming himself or herself or others if compulsion is not performed and has problems with task completion.

SPECIAL INFORMATION

The child may be reluctant to talk about the condition; parental report may be the only reliable history. Sexuality may be the underlying concern in certain cases (...).

Children are more prone to engage in rituals at home than in front of peers, teachers, or strangers.

Although obsessive-compulsive disorder usually presents in adolescence or early adulthood, it may begin in childhood. For the most part onset is gradual, but acute onset has been noted in some cases.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996) American Academy of Pediatrics

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4. Interventions

On the following pages are discussions of

- **Accomodations to Reduce Anxiety Problems**
- **Behavior Management and Self Instruction**
- **Empirically Supported Treatments for Anxiety Problems**
- **Medications Used to Treat Anxiety Problems**

Intervention:

Accommodations to Reduce Anxiety Problems at a New School

The following is excerpted from an article entitled "Changing Schools is Now the Norm, But Anxiety Problems are Not, Says UMASS Child Psychologist" that was published as a University of Massachusetts Medical Center news brief.

◆

WORCESTER, Mass. (May 1, 1996) - Childhood anxiety is being diagnosed at an increasing rate nationally, and child health experts are still identifying anxiety disorders that were unknown as little as five to 10 years ago. Among the causes for anxiety in children lies the fear and discomfort of changing schools. According to Martin H. Young, PhD, associate professor of pediatrics at the University of Massachusetts Medical Center in Worcester, it's not uncommon for a youngster to have changed schools four times before even entering high school. "Changing schools is no longer the exception, its the rule," says Dr. Young. "Not only from one town or state to the next, but there's also a tremendous number of children who regularly change schools within a single district."

While many children will adapt easily to a new school environment, others may be more vulnerable to anxiety due to pre-existing factors, notes the specialist in pediatric anxiety disorders. "Transferring to a new school can be a problem for a child who, for example, gets upset when separated from his parents," says Young, adding that separation anxiety can sometimes extend past the normal pre-school age years.

Stress in a child's life can also impair a smooth transition to a new school, says Young. "When people are stressed, they have a more difficult time making changes. There's a feeling among child professionals that kids now live in a much mor e stressful world that existed 10 to 15 years ago," notes Young. "The worry a child feels when a parent is laid-off or a family member is sick can affect his comfort in leaving home."

Children with chronic medical problems, Attention Deficit Hyperactivity Disorder or learning disabilities, may also need special help with adjusting to a new school. "These kids tend to have greater problems during even natural transitions than do children without special needs," says the UMass child psychologist.

In general, the older children are, the better they'll adapt to a new school. However, even adolescents can have a difficult time with transition, especially when they fear rejection by their new peers.

What are some of the classic signs that your child is not adjusting well to his new school?

Child is exhibiting "school avoidance" behavior, such as procrastinating in the morning before going to school, or complaining about physical discomforts (headaches, nausea, stomach ache). Very rarely do kids fake complaints of physical problems, says Young. "What's different is that their symptoms are caused by anxiety and fear, instead of a virus or bacteria." Younger-acting behavior for a period that goes on for weeks should raise suspicion. "In general, children under stress, regress," indicates Young.

Additional signs, such as complaints about a teacher or poor school performance, can also point to other problems, he warns. "The family has to understand their own particular child, and stay attuned to what behavior is normal for him. Gauge his adjustment based on your past experience and your expectations of that child."

Parents can help prepare kids for an easier transition to a new school by doing a little advance planning. "Anything that will change an unfamiliar, potentially scary experience into a familiar one will help a child," says Young. He recommends these steps:

- ✔ Visit the school before it opens up for the year. Most schools are open during the summer and the parent can ask for permission to walk around with the child. If the school system allows it, have the child meet the teacher before the end of the summer.
- ✔ If you've moved to a new neighborhood, help your child get to know the children who will be attending her school. Arrange a "buddy system" between your child and a peer from the new school.
- ✔ If your child will be riding the bus for the first time, take her for a visit to the bus company, or for a ride on public transportation.
- ✔ Inform the school if your child has special needs or requirements, such as a history of headaches or a learning disability. Parents are often hesitant to share this with the school because they're afraid the child will be labeled or stereotyped. But keeping this information from the school can deprive your child from the support she needs.

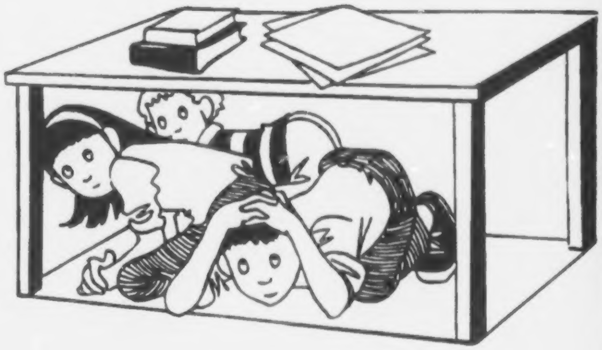
"Parents should view teachers as support agents for their child," stresses Young. "They have a lot of experience in dealing with problems associated with adapting to a new school. For parents to see the school as an ally is very helpful for the child."

If anxiety persists and problems turn from school avoidance to more serious issues, such as social isolation and depression, Young advises that parents seek help from a mental health professional. "In general, the time to seek help for the child is at the point where what you're seeing as a parent no longer feels comfortable. Parents can do a great deal in helping their children adapt to a new school simply by staying attentive to their concerns or changes in behavior."

This document is available on-line at http://www.ummed.edu/dept/main/resource/school.htm

Intervention:

Behavior Management & Self-Instruction for...



Managing Traumatic Stress

Tips for Recovering From Disasters and Other Traumatic Events*

Because you are reading this fact sheet you probably are in the process of recovering from a natural disaster or other type of traumatic event. Perhaps you experienced a flood, hurricane, or earthquake. Or maybe you have been in a serious accident or the victim of crime. Traumatic experiences such as these tend to be sudden and overwhelming. In some cases there are no outwardly visible signs of physical injury but there is nonetheless a serious emotional toll. It is common for people who have experienced traumatic situations to have very strong emotional reactions. Understanding normal responses in these abnormal events can aid you in coping effectively with your feelings, thoughts, and behaviors and help you along the path to recovery.

What happens to people after a disaster or other traumatic event?

Shock and denial are typical responses to disasters and other kinds of trauma, especially shortly after the event. Both shock and denial are normal, protective reactions.

Shock is a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed. Denial involves your not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event. You may temporarily feel numb or disconnected from life.

As the initial shock subsides, reactions vary from one person to another. The following, however, are normal responses to a traumatic event:

Feelings become intense and sometimes are unpredictable. You may become more irritable than usual, and your mood may change back and forth dramatically. You might be especially anxious or nervous, or even become depressed.

Thoughts and behavior patterns are affected by the trauma. You might have repeated and vivid memories of the event. These flashbacks may occur for no apparent reason and may lead to physical reactions such as rapid heart beat or sweating.

You may find it difficult to concentrate or make decisions, or become more easily confused. Sleep and eating patterns also may be disrupted.

Recurring emotional reactions are common. Anniversaries of the event, such as at one month or one year, as well as reminders such as aftershocks from earthquakes or the sounds of sirens, can trigger upsetting memories of the traumatic experience. These "triggers" may be accompanied by fears that the stressful event will be repeated.

Interpersonal relationships often become strained. Greater conflict, such as more frequent arguments with family members and coworkers, is common. On the other hand, you might become withdrawn and isolated and avoid your usual activities.

Physical symptoms may accompany the extreme stress. For example, headaches, nausea and chest pain may result and may require medical attention. Pre-existing medical conditions may worsen due to the stress.

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*This document is from the American Psychological Association.

How do people respond differently over time?

It is important for you to realize that there is not one "standard" pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions— sometimes months or even years later. Some have adverse effects for a long period of time, while others recover rather quickly.

And reactions can change over time. Some who have suffered from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed.

A number of factors tend to affect the length of time required for recovery, including:

- **The degree of intensity and loss.** Events that last longer and pose a greater threat, and where loss of life or substantial loss of property is involved, often take longer to resolve.

- **A person's general ability to cope with emotionally challenging situations.** Individuals who have handled other difficult, stressful circumstances well may find it easier to cope with the trauma.

- **Other stressful events preceding the traumatic experience.** Individuals faced with other emotionally challenging situations, such as serious health problems or family-related difficulties, may have more intense reactions to the new stressful event and need more time to recover.

How should I help myself and my family?

There are a number of steps you can take to help restore emotional well being and a sense of control following a disaster or other traumatic experience, including the following:

- **Give yourself time to heal.** Anticipate that this will be a difficult time in your life. Allow yourself to mourn the losses you have experienced. Try to be patient with changes in your emotional state.

- **Ask for support from people who care about you** and who will listen and empathize with your situation. But keep in mind that your typical support system may be weakened if those who are close to you also have experienced or witnessed the trauma.

Communicate your experience in whatever ways feel comfortable to you—such as by talking with family or close friends, or keeping a diary.

- **Find out about local support groups** that often are available such as for those who have suffered from natural disasters, or for women who are victims of rape. These can be especially helpful for people with limited personal support systems.

Try to find groups led by appropriately trained and experienced professionals. Group discussion can help people realize that other individuals in the same circumstances often have similar reactions and emotions.

- **Engage in healthy behaviors** to enhance your ability to cope with excessive stress. Eat well-balanced meals and get plenty of rest. If you experience ongoing difficulties with sleep, you may be able to find some relief through relaxation techniques. Avoid alcohol and drugs.

- **Establish or reestablish routines** such as eating meals at regular times and following an exercise program. Take some time off from the demands of daily life by pursuing hobbies or other enjoyable activities.

- **Avoid major life decisions** such as switching careers or jobs if possible because these activities tend to be highly stressful.

- **Become knowledgeable about what to expect** as a result of trauma. Some of the "Additional Resources" listed at the end of this fact sheet may help you with this learning process.

How do I take care of children's special needs?

The intense anxiety and fear that often follow a disaster or other traumatic event can be especially troubling for children. Some may regress and demonstrate younger behaviors such as thumb sucking or bed wetting. Children may be more prone to nightmares and fear of sleeping alone. Performance in school may suffer. Other changes in behavior patterns may include throwing tantrums more frequently, or withdrawing and becoming more solitary.

There are several things parents and others who care for children can do to help alleviate the emotional consequences of trauma, including the following:

- **Spend more time with children and let them be more dependent on you** during the months following the trauma - for example, allowing your child to cling to you more often than usual. Physical affection is very comforting to children who have experienced trauma.

- **Provide play experiences to help relieve tension.** Younger children in particular may find it easier to share their ideas and feelings about the event through non-verbal activities such as drawing.

- **Encourage older children to speak** with you, and with one another, about their thoughts and feelings. This helps reduce their confusion and anxiety related to the trauma. Respond to questions in terms they can comprehend. Reassure them repeatedly that you care about them and that you understand their fears and concerns.

- **Keep regular schedules** for activities such as eating, playing and going to bed to help restore a sense of security and normalcy.

When should I seek professional help?

Some people are able to cope effectively with the emotional and physical demands brought about by a natural disaster or other traumatic experience by using their own support systems. it is not unusual, however, to find that serious problems persist and continue to interfere with daily living. For example, some may feel overwhelming nervousness or lingering sadness that adversely affects job performance and interpersonal relationships.

Individuals with prolonged reactions that disrupt their daily functioning should consult with a trained and experienced mental health professional. Psychologists and other appropriate mental health providers help educate people about normal responses to extreme stress. These professionals work with individuals affected by trauma to help them find constructive ways of dealing with the emotional impact.

With children, continual and aggressive emotional outbursts, serious problems at school, preoccupation with the traumatic event, continued and extreme withdrawal, and other signs of intense anxiety or emotional difficulties all point to the need for professional assistance. A qualified mental health professional can help such children and their parents understand and deal with thoughts. feelings and behaviors that result from trauma.

How may I use APA as a resource?

"How to Choose a Psychologist," brochure available from the American Psychological Association (APA). To order a copy free of charge, write to the APA Office of Public Communications. 750 First Street, NE, Washington, DC 20002-4242, or call (202) 336-5700.

Contact the **APA Practice Directorate** at (202) 336-5800 for the name and telephone number of your **state psychological association.** These associations, along with **city and county psychological associations,** can refer you to psychologists in your area. They may also be able to put you in touch with **other local organizations and groups that help victims of disasters and other traumatic events.**

"Helping Children Cope," may be accessed via the APA home page on the Internet, at http://www.apa.org/kids.html

Additional Resources

Local chapters of the American Red Cross may be able to direct you to additional resources. Check your local telephone directory for the chapter nearest you.

National **Organization for Victims Assistance.** 1757 Park Rd.., NW, Washington, D.C. 20010; toll-free, 1-800-TRY-NOVA: in D.C. metropolitan area, (202) 232-6682.

Two other materials available via Internet offer additional information about coping with disaster:

"After a Disaster: Steps You Can Take to Cope With a Stressful Situation," Los Angeles County Department of Mental Health http://gladstone.uoregon.edu/~dvb/dissteps.htm

"Coping with Emotions after a Disaster," University of Illinois Cooperative Extension Service http:www.ag.uiuc.edu/~disaster/emotion.html

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202/336 5898
February 1996
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Intervention:

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Empirically Supported Treatments for Children With Phobic and Anxiety Disorders: Current Status" by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Excerpted here are the abstract, key summary tables and conclusions, and the authors' references.

Abstract of articleby T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Reviews the empirically supported status of behavioral and cognitive-behavioral interventions in the treatment of childhood phobias and anxiety disorders. For childhood phobias, it is concluded that imaginal desensitization, in vivo desensitization, filmed modeling, live modeling, and cognitive behavioral interventions that use self-instruction training are probably efficacious and that participant modeling and reinforced practice are well established. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management (FAM) were found to be probably efficacious. However, much of the support for these procedures come from analogue studies conducted in research laboratories or school settings, delivered in small group format and, not infrequently, with nonclinically referred children. Additional research that examines high-strength interventions with clinic-referred children is recommended. Furthermore, research that examines the pathological processes involved in the onset and maintenance of phobic and anxiety disorders as well as the change processes used to treat these disorders is called for.

The following pages highlight the gist of the article.

* * *

Childhood Fears and Phobias

Systematic Desensitization and Its variants

Wolpe (1958) first formulated the systematic desensitization procedure. In this paradigm, fears and phobias are viewed as classically conditioned responses that can be unlearned through specific counterconditioning procedures. In *counterconditioning*, fear-producing stimuli are presented imaginally or in vivo (real life) in the presence of other stimuli that elicit responses incompatible with fear. In this manner, the fear is said to be counterconditioned and inhibited by the incompatible response. In its most basic form, systematic desensitization consists of three components: (a) induction of an incompatible response (e.g., relaxation); (b) development of a fear-producing hierarchy; and © the systematic, graduated pairing of items in the hierarchy with the incompatible response. Generally, fear-producing stimuli are presented imaginally (in order of least to most fear producing) while the child is engaged in an incompatible behavior (e.g., relaxation). This aspect of treatment is the desensitization proper and is thought to lead to direct inhibition of the fear response. Although studies have questioned the active mechanisms and the necessary ingredients of systematic desensitization (see review by Ollendick, 1979) there is little doubt that this desensitization and its variants are frequently used procedures with children...

In sum, imaginal systematic desensitization has been found to be more effective than no treatment in four between-group design studies (Barabasz, 1973; Kondas, 1967; Mann & Rosenthal, 1969; Miller et al., 1972). Furthermore it has been found to be more effective than some alternative treatments (e.g., relaxation training) but not others (e.g., live modeling). On the basis of these studies, imaginal systematic desensitization can be said to enjoy probably efficacious status...

Modeling and Its Variants

Drawing on vicarious conditioning principles, modeling capitalizes on the power of observational learning to overcome children's fears and phobias. The theoretical and empirical bases of modeling as a treatment procedure have been articulated by Bandura and his colleagues (e.g., Bandura, 1971). Theoretically, the extinction of avoidance responses is thought to occur through observation of modeled approach behavior directed toward a feared stimulus without adverse consequences accruing to the model. In its most basic procedural form, it entails demonstrating nonfearful behavior in the anxiety-provoking situation and showing the child a more adaptive and appropriate response for handling or dealing with the feared object or event. Modeling can be symbolic (filmed) or live; furthermore, the phobic child can be assisted in approaching the feared stimulus (participant modeling) or prompted to display the modeled behavior without such assistance. In all of these procedural variations, anxiety is thought to be reduced and a new skill to be acquired (Bandura, 1969)...

Thus, on the basis of these nine studies, it can be concluded that filmed modeling and live modeling are probably efficacious procedures. Both have been shown to be superior to no-treatment conditions with a variety of excessive fears and phobias. Participant modeling, on the other hand, enjoys well-established status. It is more effective than filmed and live modeling as well as standard (imaging) systematic desensitization.

Contingency Management

In contrast to systematic desensitization, modeling, and their variants, which all assume that fear must be reduced or eliminated before approach behavior will occur, contingency management procedures make no such assumption. Derived from principles of operant conditioning, contingency management procedures attempt to alter phobic behavior by manipulating its consequences (King & Ollendick, 1997). Operant-based procedures assert that acquisition of approach responses to the fear-producing situation is sufficient and that anxiety reduction, per se, is not necessary. Shaping, positive reinforcement and extinction are the most frequently used contingency management procedures to reduce phobic behavior...

Thus, on the basis of these four between-group design studies, it can be concluded that reinforced practice has also earned well-established status: It has been shown to be more effective than no-treatment control conditions in two studies (Leitenberg & Callahan, 1973; Obler & Terwilliger, 1970) and to be superior to two other treatment modalities--verbal coping skills (Sheslow, et al., 1983) and live (adult) modeling (Menzies & Clarke, 1993), both of which have been shown to be more effective than no treatment.

Cognitive-Behavioral Procedures

Cognitive-behavioral procedures include a variety of strategies designed to alter perceptions, thoughts, images, and beliefs of phobic children by manipulating and restructuring their distorted, maladaptive cognitions. Because these maladaptive cognitions are assumed to lead to maladaptive behavior (e.g., phobic avoidance), it is asserted that cognitive changes will produce behavior changes.

Results from these two between-group studies indicate that interventions based on self-instructional training and related cognitive procedures are more effective than no-treatment and wait-list control groups. However, they have not been systematically compared to other treatments, and as a result, they can only be viewed as probably efficacious at this time. Their well-established status awaits additional research.

Summary

On the basis of this brief review, a variety of behavioral and cognitive-behavioral interventions have been shown to be more effective in the treatment of childhood fears and phobias than wait-list control conditions. In addition, some of these interventions have been shown to be superior to placebo or other treatments. As indicated in Table 1, imaginal desensitization, in vivo desensitization, filmed modeling, live modeling, and self-instruction training all enjoy probably efficacious status. Moreover, participant modeling and reinforced practice enjoy well-established status. Emotive imagery, on the other hand, can only be described as experimental at this time. Having noted those generally positive outcomes, however, it should be quickly asserted that even these behavioral and cognitive-behavioral procedures are in need of considerable additional empirical support. Extant support is meager at best. Although children were randomly assigned to treatment conditions in the studies reviewed, characteristics of the samples were only minimally specified (e.g., age, sex, diagnosis/extent of fear), adequate statistical power was notably lacking (the sample sizes were small in most studies) and only rarely were manuals used in treatment. (However, note that the bulk of these studies were completed prior to the advent of manualization and that, for the most

Table 1. *Summary of EST Status of Behavioral and Cognitive-Behavioral Treatments for Phobias and Anxiety Disorders in Children and Adolescents*

Treatment	EST Status
For Phobias	
Systematic Desensitization and Its variants	
Imaginal Desensitization	Probably Efficacious
In Vivo Desensitization	Probably Efficacious
Emotive Imagery	Experimental
Modeling and Its Variants	
Live Modeling	Probably Efficacious
Filmed Modeling	Probably Efficacious
Participant Modeling	Well-Established
Operant Procedures	
Reinforced Practice	Well-Established
Cognitive-Behavioral Procedures	
Cognitive-Behavior Therapy	Probably Efficacious
For Anxiety Disorders	
Cognitive Behavioral Procedures	
Cognitive-Behavior Therapy	Probably Efficacious
Cognitive-Behavior Therapy + Family Anxiety Management	Probably Efficacious

part, procedures were sufficiently specified to permit replication and validation.) Moreover, as evident in Table 2, much of the support has come from analogue studies that have been conducted in research or school settings and delivered in small-group format and, not infrequently, with nonclinically referred children. As such, the children and the treatment in many of these studies may have differed substantially from that offered in clinic settings to clinic-referred children and their families (see Kazdin, 1997; Weisz, Donenberg, Han, & Weiss, 1995; Weisz, Weiss, & Donenberg, 1992). Furthermore, studies examining the efficacy of "one-session" treatment (Ost, 1989) of specific phobias in children are notably lacking. A combination of exposure in vivo, modeling, and reinforced practice, this procedure has been found to be a rapid and effective treatment for phobias in adults (Ost; 1997). Its efficacy with children awaits systematic inquiry (Ollendick, Hagopian, & King, 1997). Finally, the efficacy of these treatments has not been examined with other anxiety disorders of childhood (e.g., separation anxiety disorder, generalized anxiety disorder, panic disorder). Their use has been restricted to clinical fears and phobias.

Anxiety Disorders

Surprisingly, no controlled between-group design studies examining the efficacy of psychotherapy with children evincing anxiety disorders, other than simple or specific phobias, existed until recent years (Hagopian & Ollendick, 1997). Nonetheless several single-case design studies provided preliminary evidence for the likely utility of behavioral and cognitive-behavioral procedures with overanxious and separation anxious youth (e.g., Eisen & Silverman, 1993; Hagopian, Weist, & Ollendick, 1990; Kane & Kendall, 1989; Ollendick, 1995; Ollendick, Hagopian, & Huntzinger, 1991). These early studies provided the foundation for the between-group design studies that followed. Four such between-group studies have been undertaken in recent years. All evaluate the efficacy of cognitive-behavioral therapy.

Cognitive-behavioral treatment (CBT) for anxiety disorders in children, as pioneered by Kendall and his colleagues (e.g., Kendall et al., 1992), is focused on four major cognitive components (a) recognizing anxious feelings and somatic reactions to anxiety, (b) clarifying cognitions in anxiety-provoking situations (i.e., unrealistic or negative attributions or expectations), (c) developing a plan to help cope with the situation (i.e., modifying anxious self-talk as well as determining what coping actions might be effective), and (d) evaluating the success of the coping strategies and self-reinforcement as appropriate. These cognitive strategies are used to assist the child to recognize anxious cognitions, to use awareness of these cognitions as cues for managing their anxiety, and to help them cope more effectively in anxiety-provoking situations.

In addition, behavioral strategies such as modeling, in vivo exposure, role play, relaxation training, and reinforced practice are used (Kane & Kendall, 1989; Kendall et. al., 1992). Thus, these cognitive-behavioral procedures are broad in scope and incorporate many of the elements of treatments used with phobic children...

Summary

Based on these four, well-controlled, between-group design studies, it is evident that cognitive-behavioral therapy alone and cognitive-behavior therapy plus family anxiety management are probably efficacious in the treatment of anxiety disorders in children. Moreover, preliminary evidence suggests the inclusion of the family anxiety management component will enhance CBT's efficacy and result in a well-established treatment. Such a conclusion is consistent with recent experimental evidence that affirms the role of family (especially parental) enhancement of avoidant responses in anxious children (see Barrett, Rapee, Dadds & Ryan, 1996; Dadds, Berrett, Rapee, & Ryan, 1996) and the need to involve family members more centrally in the therapeutic process with anxious children (see Ginsburg, Silverman, & Kurtines 1995; Ollendick & Ollendick, 1997).

The studies to date, using what Kazdin (1993) referred to as "treatment package" and "constructive treatment" evaluative strategies, provide an affirmative response to the question, Does treatment (CBT) produce therapeutic change? In the case of CBT, What components or other treatments can be added to enhance therapeutic change (i.e., family anxiety management)? However, many questions about the effectiveness of treatment remain, including what processes within treatment influence (mediate) outcome and what child, parent, family, and contextual features influence (moderate) outcome (Kazdin, 1997). A host of clinical issues salient to the implementation and evaluation of these treatments also remain (see Ollendick & Ollendick, 1997; Silverman, Ginsburg, & Kurtines, 1995).

Table 2: *EST Criteria and the Status of Behavioral and Cognitive-Behavioral Treatments of Fear and Phobias in Children and Adolescents*

	Superior to Pill, Placebo, or Other Treatments	**Equivalent to Established Treatment**	**Superior to Waitlist Control Group**	**Treatment Manual**	**Client Characteristics Specified**	**Clinical Analogue**
Systemic Desensitization and Its Variants						
Imaginal Desensitization						
Kondas (1967)	Yes[a]	NA	Yes	No	Yes	Analogue
Mann & Rosenthal (1969	No[b]	NA	Yes	No	Yes	Analogue
Barabasz (1973)	NA	NA	Yes	No	Yes	Analogue
Miller et al. (1972)	No[c]	NA	Yes	No	Yes	Clinical
In Vivo Desensitization						
Ultee et al. (1982)	Yes[d]	NA	Yes	No	Yes	Clinical
Kuroda (1969)	NA	NA	Yes	No	Yes	Analogue
Emotive Imagery						
Cornwall et al. (1997)	NA	NA	Yes	No	Yes	Clinical
Modeling and Its Variants						
Live Modeling						
Mann & Rosenthal (1969)	No[b]	NA	Yes	No	Yes	Analogue
Bandura et al. (1967)	Yes[e]	NA	Yes	No	Yes	Analogue
Filmed Modeling						
Bandura & Menlove (1968)	NA	NA	Yes	No	Yes	Analogue
Hill et al. (1968)	NA	NA	Yes	No	yes	Analogue
Participant Modeling						
Lewis (1974)	Yes[f]	NA	Yes	No	Yes	Clinical
Ritter (1968)	Yes[g]	NA	Yes	No	Yes	Analogue
Bandura et al. (1969)	Yes[h]	NA	Yes	No	Yes	Clinical
Blanchard (1970)	NA	NA	Yes	No	Yes	Clinical
Murphy & Bootzin (1973)	NA	NA	Yes	No	Yes	Analogue
Operant Procedures						
Olber & Terwilliger (1970)	NA	NA	Yes	No	Yes	Clinical
Leitenberg & Callahan (1973)	NA	NA	Yes	No	Yes	Analogue
Sheslow et al. (1983)	Yes[i]	NA	Yes	No	Yes	Clinical
Menzies & Clark (1993)	Yes[j]	NA	Yes	No	Yes	Clinical
Cognitive-Behavioral Procedures						
Kanfer et al. (1975)	Yes[k]	NA	Yes	No	Yes	Analogue
Graziano & Mooney (1980)	NA	NA	Yes	No	Yes	Clinical

NOTE: [a]Imaginal desensitization > relaxation training. [b]Imaginal desensitization = live modeling. [c]imaginal desensitization = psychotherapy. [d]In vivo desensitization > imaginal desensitization. [e]Live modeling = imaginal desensitization; both > positive placebo context. [f]Participant modeling > filmed modeling. [g]Participant modeling > filmed modeling. [h]Participant modeling > filmed modeling; participant modeling > imaginal desensitization. [i]Reinforced practice > verbal self-instruction. [j]Reinforced practice > live modeling. [k]Competence statements > stimulus statements > neutral statements.

Conclusions and Future Directions

At this juncture, it appears critical that we take additional steps to establish truly clinically efficacious treatments for children with phobic and anxiety disorders. Integrated treatments proposed early on by Ollendick (1979) and illustrated in the recent work of Heard, Dadds, and Conrad (1992) represent such efforts and show considerable promise. Heard, et al. (1992), for example, designed an integrated treatment package for phobic children consisting of in vivo exposure, participant modeling, reinforced practice, self-instruction training, and home contingency management. Results on self-report, parent-report, and behavioral measures affirmed the effectiveness of the integrated procedures, in addition, family functioning in terms of cohesion increased as a result of treatment. The development and evaluation of such high-potency, "total push" interventions with clinic-referred children seem critical as our next step. Both well-controlled, single-case designs and full-fledged, randomized clinical trials will likely prove useful in this regard. Subsequent to demonstrated efficacy with such interventions, dismantling and parametric studies might follow to establish critical components of the treatment packages, as suggested by Kazdin (1997). In such studies, it will also be necessary to specify treatment procedures (preferably through manualization) and to determine whether the treatments actually alter those processes that are conceptualized as critical in the treatment model (e.g., do changes in self-efficacy for dealing with agoraphobic avoidance or changes in distorted cognitions actually occur in cognitive-behavioral intervention; see Eisen & Silverman, 1993; Ollendick, 1995). Hypothesized treatment processes, of course, should also be linked to the conceptualization of the psychopathological processes involved in the etiology of the disorder, as suggested by Shirk and Russell (1996). Basically, the treatment should match or address the processes hypothesized to be related to the onset and maintenance of the disorder. The goodness of fit of such an intervention should be related to treatment outcome. Finally, it also will be necessary to explore the boundary conditions under which the interventions are found to be effective (i.e., establish the moderators of effective treatment outcome). The phrase "what works for whom and under what conditions" has long been espoused; however, it has rarely been realized.

In sum, limited progress has been made in development of efficacious treatment procedures for children with anxiety and phobic disorders. Much remains to be accomplished. Although one is tempted to conclude that we simply need more research, such a conclusion would be ill-advised and short-sighted. We do need more research, but we do not need more research like that which has been conducted in the past. Rather we need more research that is methodologically sound and that extends the evaluation of our treatment procedures to clinic-referred children in clinic settings, much like the research that has occurred in the recent studies conducted by Kendall and colleagues. That is a start. In addition, we need qualitatively different research that addresses processes and outcomes in a more sophisticated and conceptually rich manner in order to make significant advances. The challenge lies before us.

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Intervention:

PSYCHOTROPIC MEDICATIONS CATEGORIZED BY CHILD /ADOLESCENT DIAGNOSIS*

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

Anxiety Disorders

anti-depressants
imipramine [Tofranil, Janimine]

anxiolytics
buspirone hydrochloride [BuSpar]
chlordiazepoxide [Librium]
alprazolam [Xanax]

anti-histamines
diphenhydramine [Benedryl]
hydroxyzine hydrochloride [Atarax]
hydroxyzine pamoate [Vistaril]

School Phobia

anti-depressants
imipramine [Tofranil, Janimine]

anxiolytics
chlordiazepoxide [Librium]
alprazolam [Xanax]
buspirone hydrochloride [BuSpar]

Obsessive-Compulsive Disorder

anti-depressants:
fluoxetine [Prozac]
clomipramine hydrochloride [Anafranil]

*Because many side effects are not predictable, all psychotropic medication requires careful, ongoing monitonng of psychological and physical conditions. Pulse, blood pressure, and signs of allergic reactions need to be monitored frequently, and when medication is taken for prolonged periods, periodic testing of hematological, renal, hepatic, and cardiac functions are essential. Prior to any other physical treatment (surgery, dentistry, etc.), it is important to inform physicians/ dentists that psychotropic medication is being taken. Finally, common side effects of many medications are drowsiness/ insomnia and related factors that can interfere with effective school performance.

MEDICATION AND ANXIETY DISORDERS

From the National Institute of Mental Health Website: Http://www.nimh.nih.gov/publicat/
The material has been abridged for use here to highlight information about psychotropic medication frequently prescribed for children and adolescents.

> Individuals with anxiety disorders may feel anxious most of the time, without any apparent reason. Or the anxious feelings may be so uncomfortable that to avoid them the individual may stop some everyday activities. Some individuals have occasional bouts of anxiety so intense they terrify and immobilize them.
>
> Anxiety disorders are the most common of all the mental disorders. At the National Institute of Mental Health (NIMH)--the Federal agency that conducts and supports research related to mental disorders, mental health, and the brain--scientists are learning more and more about the nature of anxiety disorders, their causes, and how to alleviate them. NIMH also conducts educational outreach activities about anxiety disorders and other mental illnesses.

Generalized Anxiety Disorder

> Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It is characterized as chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money family or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

Panic Disorder

> People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. In between times there is a persistent, lingering worry that another attack could come any minute.
>
> Panic disorder is often accompanied by other conditions such as depression or alcoholism, and may spawn phobias, which can develop in places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding an elevator, you may develop a fear of elevators and perhaps start avoiding them. Some people find the greatest relief from panic disorder symptoms when they take certain prescription medications. Such medications, like cognitive-behavioral therapy, can help to prevent panic attacks or reduce their frequency and severity. Two types of medications that have been shown to be safe and effective in the treatment of panic disorder are antidepressants and benzodiazepines.

Phobias

Phobias occur in several forms. A specific phobia is a fear of a particular object or situation. Social phobia is a fear of being painfully embarrassed in a social setting. And agoraphobia, which often accompanies panic disorder, is a fear of being in any situation that might provoke a panic attack, or from which escape might be difficult if one occurred.

About 80 percent of people who suffer from social phobia find relief from their symptoms when treated with cognitive-behavioral therapy or medications or a combination of the two. Therapy may involve learning to view social events differently; being exposed to a seemingly threatening social situation in such a way that it becomes easier to face; and learning anxiety-reducing techniques, social skills, and relaxation techniques. The medications that have proven effective include antidepressants called MAO inhibitors. People with a specific form of social phobia called performance phobia have been helped by drugs called beta-blockers. For example, musicians or others with this anxiety may be prescribed a beta-blocker for use on the day of a performance.

Obsessive-Compulsive Disorder

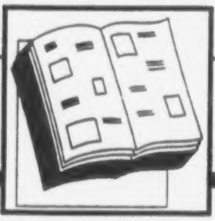
Obsessive-compulsive disorder is characterized by anxious thoughts or rituals you feel you can't control. If you have OCD, as it's called, you may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals.

Research by NIMH-funded scientists and other investigators has led to the development of medications and behavioral treatments that can benefit people with OCD. A combination of the two treatments is often helpful for most patients. Some individuals respond best to one therapy, some to another. Two medications that have been found effective in treating OCD are clomipramine and fluoxetine.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD, once referred to as shell shock or battle fatigue, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents

Antidepressants and anxiety-reducing medications can ease the symptoms of depression and sleep problems, and psychotherapy, including cognitive-behavioral therapy, is an integral part of treatment. Being exposed to a reminder of the trauma as part of therapy -- such as returning to the scene of a rape -- sometimes helps. And, support from family and friends can help speed recovery.



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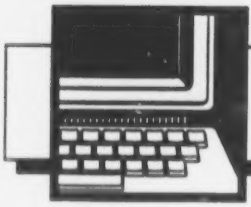

Agencies and Online Resources Related to Anxiety Problems and Disorders

Anxiety Disorders Association of America

Promotes the prevention and cure of anxiety disorders and works to improve the lives of all people who suffer from them. ADDA is made up of professionals who conduct research and treat anxiety disorders and individuals who have a personal or general interest in learning more about such disorders. The website provides access to the latest books, tapes, journal articles and to listings of self-help/support groups and experienced treatment providers in your area.

Contact: 11900 Parklawn Drive, Suite 100, Rockville, MD 20852, USA
http://www.adaa.org/

The Anxiety Network International

The Anxiety Network is an international outreach to educate and inform the general public about the anxiety disorders, and to educate and support people with anxiety disorders. The website provides information, support, and therapy for the largest anxiety disorders: social anxiety (social phobia), panic/agoraphobia, and generalized anxiety.

Contact: Dr. Thomas Richards, 4643 East Thomas, Suite 6, Phoenix, AZ, 85018-7740, Phone: (602) 952-9846, ascaz@CONCENTRIC.NET, www.anxietynetwork.com

Center for Anxiety and Stress Treatment

The site contains on-line articles, self-help book, audio-tape based anxiety reduction program, group manual, and workshops. Mission is to provide resources which can help consumers manage a regain their

Contact: Stress Release Health Enterprises, Shirley Babior, LCSW, Center for Anxiety and Stress Treatment, 4225 Executive Square, Suite 1110, La Jolla, CA 92037, Phone: (619) 542-0536, fax: (619) 542-0730,
E-mail: health@stressrelease.com http://www.stressrelease.com/

National Mental Health Consumers' Self-Help Clearinghouse

This consumer-run national technical assistance center promotes consumer/survivor participation in planning, providing, and evaluating mental health and community support services. It provides technical assistance and information to consumers/providers interested in developing self-help services and advocating to make traditional services more consumer oriented.

Contact: 1211 Chestnut Street, Philadelphia, PA 19107 Phone: (800) 553-4539

NIMH Anxiety Disorders Education Program

A national education campaigned developed by the National Institute of Mental Health (NIMH) to increase awareness among the public and health care professionals that anxiety disorders are real medical illnesses that can be effectively diagnosed and treated. It seeks to counter widespread lack of understanding and stigma that prevents many people from being diagnosed and receiving treatments that have been proven effective.

Contact: 5600 Fishers Lane, Room 7C-02, MSC 8030, Bethesda, MD 20892-8030
NIMH Panic Information Line: 1-800-64-Panic, NIMH Toll-free Information Services: 1-88-88-ANXIETY, http://www.nimh.nih.gov/anxiety/

Obsessive-Compulsive Foundation, Inc.

An international not-for-profit organization composed of people with obsessive compulsive disorder (OCD) and related disorders, their families, friends, professionals and other concerned individuals. The mission is to educate the public and professional communities about OCD; to provide assistance to individuals with OCD; and to support research into the causes and effective treatments of OCD and related disorders.

Contact: P.O. Box 70, Milford, CT 06460-0070, Phone: (203) 878-5669
Fax: (203)874-2826, E-mail: info@ocfoundation.org, www.ocfoundation.org

The OCD Resource Center of South Florida

Disseminates information about new developments in the treatment ofobsessive-compulsive disorder (OCD). Estimates that more than three to five million adults and 500,000 children nationwide suffer from this seriously disabling disorder. The website describes available services for children and adults including assessment and evaluation, medication, individual cognitive-behavior therapy, group and family therapy.

Contact: 3475 Sheridan Street, Suite 310, Hollywood, Florida 33021
Phone: (954) 962-6662, Fax: (954) 962-6164, http://www.ocdhope.com

Open Doors Institute

Based on techniques developed by Dr. Lynne Freeman, this organization provides cognitive-behavioral therapy, psychiatric evaluation, phone sessions, and an available network of providers.

Contact: 13601 Ventura Blvd., Suite 600, Sherman, Oaks, California 91423
Phone: 818-710-6442 info@opendoorsinstitute.com
www.opendoorsinstitute.com/serv03.htm

The Ross Center for Anxiety and Related Disorders, Inc.

A nationally-known comprehensive, outpatient facility in Washington, DC, which offers state-of-the-art treatment for anxiety disorders. Offers an accelerated, flexible Intensive Treatment Program ideal for individuals living in other parts of the country who wish to be treated at the center.

Contact: 4545 42nd Street, N.W., Suite 311, Washington, D.C. 20016
Phone: 202-363-1010 http://www.rosscenter.com/contact.cfm

Contents of Section III D:

Affect and Mood Problems

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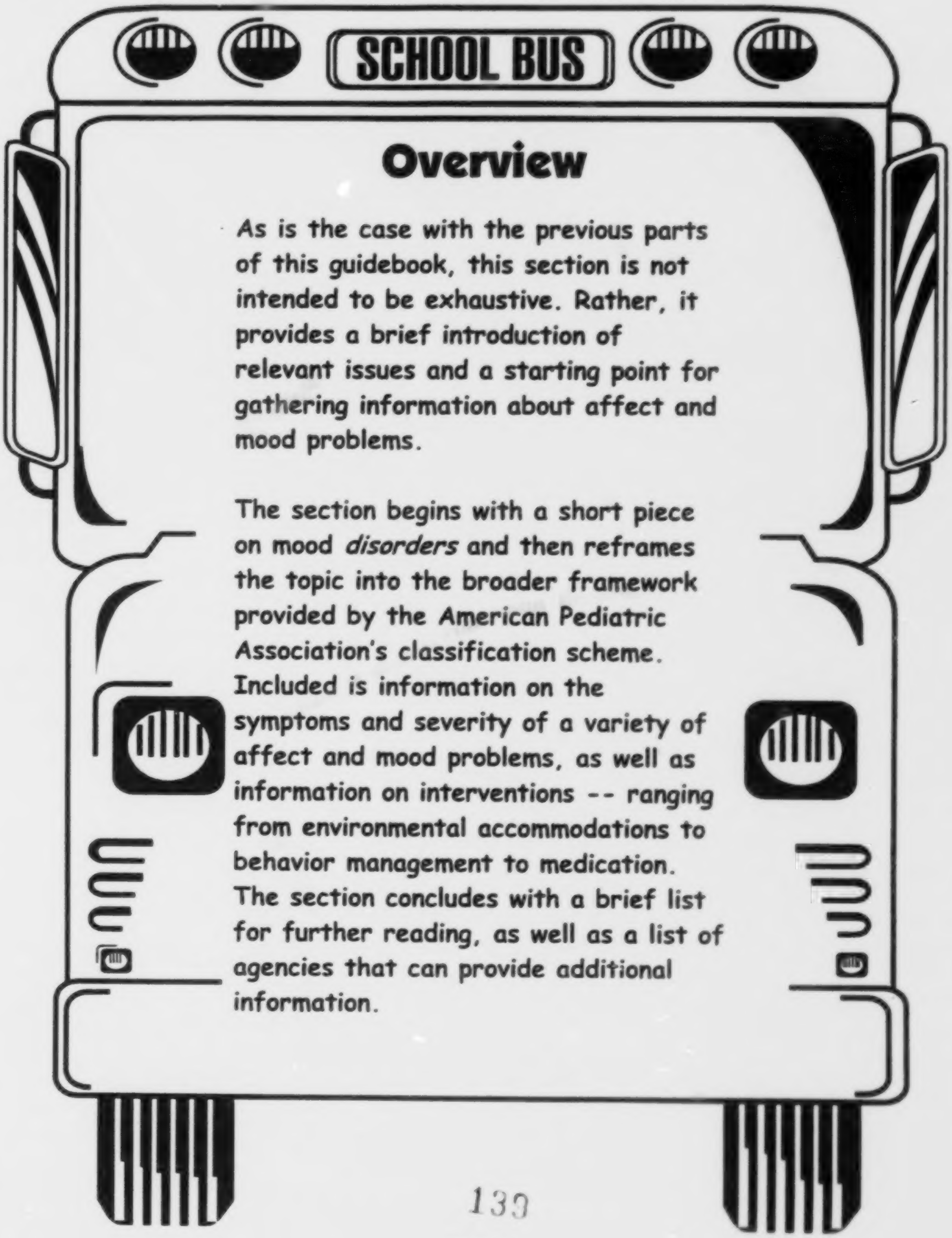
   - Accommodations

   - Behavior Management: Suicide Crisis

   - Empirically Supported Treatment

   - Medication

5. A Few References and Other Sources of Information



Overview

As is the case with the previous parts of this guidebook, this section is not intended to be exhaustive. Rather, it provides a brief introduction of relevant issues and a starting point for gathering information about affect and mood problems.

The section begins with a short piece on mood *disorders* and then reframes the topic into the broader framework provided by the American Pediatric Association's classification scheme. Included is information on the symptoms and severity of a variety of affect and mood problems, as well as information on interventions -- ranging from environmental accommodations to behavior management to medication. The section concludes with a brief list for further reading, as well as a list of agencies that can provide additional information.

Mood Disorders in Children and Adolescents

by Anne Brown

Adapted from an an article of the same name in the NARSAD Research Newsletter, Winter 1996.

Many researchers believe that mood disorders in children and adolescents represent one of the most under diagnosed group of illnesses in psychiatry. This is due to several factors:

(1)children are not always able to express how they feel,
(2) the symptoms of mood disorders take on different forms in children than in adults,
(3) mood disorders are often accompanied by other psychiatric disorders which can mask depressive symptoms, and
(4) many physicians tend to think of depression and bipolar disorder as illnesses of adulthood.

Not surprisingly, it was only in the 1980's that mood disorders in children were included in the category of diagnosed psychiatric illnesses.

How Prevalent are Mood Disorders in Children and Adolescents?

7-14% of children will experience an episode of major depression before the age of 15.
20-30% of adult bipolar patients report having their first episode before the age of 20.
Out of 100,000 adolescents, two to three thousand will have mood disorders out of which 8-10 will commit suicide.

Depression

There is emerging evidence that major depression can develop in prepubertal children and that it is a significant clinical occurrence among adolescents. Recent epidemiologic studies have shown that a large proportion of adults experience the onset of major depression during adolescence and early adulthood.

By studying high-risk populations for developing childhood mood disorders, researchers hope to learn more about the onset and course of depression. Myrna M. Weissman, Ph.D. of Columbia University (a NARSAD Established Investigator and 1994 Selo Prize Co-Winner) has found an increased prevalence of major depression as well as a variety of other psychiatric problems in the children of depressed parents compared with those of normal parents. Specifically, she has discovered that the onset of major depression was significantly earlier in both male and female children of depressed parents (mean age of 12.7 years) compared with those of normal parents (mean age, 16.8 years). She has also observed sex differences in rates of depression to begin in adolescence. Before 10 years of age, she found a low frequency and equal sex ratio, however by 16 years of age, there was a marked increase in major depression in girls, as compared to boys of the same age.

The essential features of mood disorders are the same in children as in adults, although children exhibit the symptoms differently. Unlike adults, children may not have the vocabulary to accurately describe how they feel and, therefore may express their problems through behavior. The following behaviors may be associated with mood disorders in children:

- *In Preschool Children*:

  Somber Appearance, almost ill-looking; they lack the bounce of their nondepressed peers. They may be tearful or spontaneously irritable, not just upset when they do not get their way. They make frequent negative self-statements and are often self-destructive.

- *In Elementary School-Aged Children and Adolescence*:

  Disruptive behavior, possible academic difficulties, and peer problems. Increased irritability and aggression, suicidal threats, and worsening school performance. Parents often say that nothing pleases the children, that they hate themselves and everything around them.

Bipolar Disorder

There has been a great deal of diagnostic uncertainty surrounding bipolar disorder in children. This may be caused by a major difference in the way mania is expressed in bipolar children versus adults. A look back at the histories of adults with bipolar symptoms often shows that mood swings began around puberty, however there is a frequent 5-to-10 year lag between the onset of symptoms and display of the disorder serious enough to be recognized and require treatment, resulting in the under diagnosis of bipolar disorder.

Unlike adult bipolar patients, manic children are seldom characterized by euphoric mood. Rather, the most common mood disturbance in manic children may be better described as irritable, with "affective storms" or prolonged and aggressive temper outbursts. For example, a study by Gabrielle A. Carlson, M.D. of State University of New York-Stony Brook, found that bipolar children under the age of 9 had more irritability, crying, and motor agitation as compared to older bipolar children, who were more likely to have "classically manic symptoms" such as euphoria and grandiosity. In addition, it has been suggested that the course of childhood-onset bipolar disorder tends to be chronic and continuous rather than episodic and acute, as is the adult form of the disorder.

Other aspects that make diagnosing bipolar disorder in children difficult is the frequency with which bipolar disorder is mistaken for attention-deficit hyperactivity disorder (ADHD), conduct disorder (which includes symptoms of socially unacceptable, violent or criminal behavior), or schizophrenia.

Bipolar Disorder vs. Other Childhood Disorders

ADHD and bipolar disorder have many overlapping features which include: distractibility, inattention, impulsivity, and hyperactivity. However, bipolar disorder has several differentiating features, which include: psychosis, depression, aggression, excitability, rapid mood swings, inappropriate affect and disregard for feelings of others.

Conduct disorder overlaps with bipolar disorder on symptoms such as: impulsivity, shoplifting, substance abuse, difficulties with the law and aggressiveness . However, in bipolar disorder, some distinguishing factors include: antisocial behavior with elevated or irritable mood and lack of peer group influence.

When comparing schizophrenia and bipolar, their common symptoms include: grandiose and paranoid delusions and hallucinatory phenomena. However, in schizophrenia, differentiating features include: thought disorder and bizarre delusions.

The widely accepted belief that childhood-onset mania is rare has recently been challenged. Many researchers including Janet Wozniak, M.D. of Harvard Medical School (a NARSAD Young Investigator) have shown a major overlap in the symptoms of mania and ADHD. Dr. Wozniak believes that this overlap may be responsible for the under identification and misdiagnosis of bipolar disorder. In her study of clinically referred children, she found 16% to have mania with irritable and mixed moods (i.e. with symptoms of depression and mania occurring simultaneously). Also, she found that the children meeting the criteria for mania frequently also met the criteria for ADHD (the rate of ADHD in children with mania was 98%, while the rate of mania in children with ADHD was only 20%).

Schizophrenia has also been found to be mistaken for manic depression in adolescents. Despite the fact that psychotic features are a well-established part of adolescent manic-depressive illness, many clinicians continue to believe that thought disorder, grandiosity, and bizarre delusional and hallucinatory phenomena are distinctively characteristic of schizophrenia. Difficulties often arise in differentiating blunted from depressive affect and apathy from depression-induced delay in response time to questions.

Treatments

It is important for children suffering from mood disorders to receive prompt treatment because early onset places children at a greater risk for multiple episodes of depression throughout their life span. Children who experience their first episode of depression before the age of 15 have a worse prognosis when compared with patients who had a later onset of the disorder.

At the present time, there is no definitive treatment for the spectrum of mood disorders in children, although some researchers believe that children respond well to treatment because they readily adapt and their symptoms are not yet entrenched. Treatment consists of a combination of interventions. Medications can be useful for cases of major depression or childhood onset mania, and psychotherapy can help children express their feelings and develop ways of coping with the illness. Some other helpful interventions that may be used are educational and family therapy.

Children suspected of mood disorders should be evaluated by a child psychiatrist, or if one is not available an adult psychiatrist who has experience in treating children. It is important that the clinician has had special training in speaking with children, utilizing play therapy, and can treat children in context of a family unit.

Suicide

An estimated 2,000 teenagers per year commit suicide in the United States, making it the leading cause of death after accidents and homicide. According to David Schaffer, M.D., of Columbia University (a NARSAD Established Investigator), suicidal behavior is uncommon before puberty, with the incidence of suicide attempts reaching its peak at around age 15 and becoming less common by the late teens. Studies of adolescent suicides in New York, Pittsburgh and Finland indicate that approximately 90 percent of the teenagers who commit suicide have a psychiatric diagnosis, most often a form of mood disorder and/or alcohol or substance abuse.

As in adults, suicide attempts occur more often in females (a ratio of 9 to 1), with overdose and wrist-cutting the most common means. Completed suicide occurs more often in males (a ratio of 3 to 1), usually white males, with shooting (62 percent) and hanging (19 percent) the most common means.

Biological Theories on Suicide

A number of biological theories are emerging to explain suicidal behavior. The available evidence points to hyposerotonergic functioning in studies of both completers and attempters. In suicide victims' brains, an increase in postsynaptic 5-hydroxytryptamine type 2 (5-HT2) receptors was found in the prefrontal cortex, suggesting that a compensatory increase in receptor density occurred in response to decreased serotonin release. The most robust findings in postmortem brains have been the measurements of low levels of serotonin (5-HT) and its major metabolite, 5-hydroxyindoleacetic acid (5-HIAA). Those findings were localized to the brainstem (the level of cell bodies) and were not found in the cortex. Completers have also shown alterations in noradrenergic (the activation of norepinephrine in the transmission of nerve impulses) but not cholinergic (of autonomic nerve fibers) pathways.

Several clinical studies have also found evidence of family histories of suicidal behavior, suggesting the likelihood of genetic factors playing a role in suicide. Twin studies provide evidence for genetic transmission of this vulnerability as twins share the same environment but differ in number of genes shared. Of 150 sets of twins reported in which at least one twin committed suicide, all 10 of the pairs in which both committed suicide were identical twins, and half of those were concordant for the same psychiatric illness.

Identifying the Vulnerable

Dr. Schaffer believes that screening out the vulnerable groups of children and adolescents for the risk factors of suicide and then referring them for treatment is the best way to lower the staggering teenage suicide rate. Students are regarded as high-risk if they have indicated suicidal ideation within the last three months, if they have ever made a prior suicide attempt, or if they indicate severe mood problems, excessive alcohol consumption or substance use.

In summary, mood disorders in children and adolescents are much more common than was originally estimated. This underestimation was primarily due to the diagnostic confusion surrounding overlapping symptoms from other childhood disorders and the difference in the expression of mania in children versus adults. Many research efforts are underway to better diagnose and identify the children and adolescents who are at risk for mood disorders. It is hoped that by identifying the most vulnerable individuals and providing them with treatment, we will finally start to see a decline in the staggering suicide rates for adolescents.

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Sadness Variation

Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.

Bereavement

Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger.

Early Childhood
The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.

Middle Childhood
The child feels transient loss of self-esteem over experiencing failure and feels sadness with losses as in early childhood.

Adolescence
The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

SPECIAL INFORMATION

A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited.

Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

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DEVELOPMENTAL VARIATION

Thoughts of Death Variation

Anxiety about death in early childhood.

Focus on death in middle childhood or adolescence.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not relevant at this age.

Early Childhood
In early childhood anxiety about dying may be present

Middle Childhood
Anxiety about dying may occur in middle childhood, especially after a death in the family.

Adolescence
Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

DEVELOPMENTAL VARIATION

Thoughts of Death Problem

The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts (next page).

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess

Early and Middle Childhood
The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence
The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- ☐ depressed/irritable mood
- ☐ diminished interest or pleasure
- ☐ weight loss/gain, or failure to make expected weight gains
- ☐ insomnia/hypersomnia
- ☐ psychomotor agitation/retardation
- ☐ fatigue or energy loss
- ☐ feelings of worthlessness or excessive or inappropriate guilt
- ☐ diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood
The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood
The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence
Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care.* (1996) American Academy of Pediatrics

Notes: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

DISORDERS

Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

☐ depressed/irritable
☐ diminished interest or pleasure
☐ weight loss/gain
☐ insomnia/hypersomnia
☐ psychomotor agitation/retardation
☐ fatigue or energy loss
☐ feelings of worthlessness
☐ diminished ability to think/concentrate
☐ recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable (e.g., severely depressed) caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the "problem" level, require significant interventions.

Early Childhood
This situation in early childhood is similar to infancy.

Middle Childhood
The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence
The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of "nerves" and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or "imbalance" (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present over 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a "normal" grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

DISORDER

Dysthymic Disorder

The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

- ☐ poor appetite/overeating
- ☐ insomnia/hypersomnia
- ☐ low energy or fatigue
- ☐ poor concentration/difficulty making decisions
- ☐ feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see DSM-IV Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood and Adolescence
Commonly experience feelings of inadequacy, loss of interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

Note: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Not diagnosed.

Early Childhood
Rarely diagnosed.

Middle Childhood
The beginning symptoms as described for adolescents start to appear.

Adolescence
During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenegenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

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DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Unable to assess.

Early Childhood
The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood
The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence
The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. However, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics.

Note:Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

4. Interventions

On the following pages are discussions of

- **Accomodations to Reduce Affect and Mood Problems**
- **Behavior Management: Suicide Crisis**
- **Empirically Supported Treatments for Affect and Mood Problems**
- **Medications Used to Treat Affect and Mood Problems**

Intervention:

Accommodations to Reduce Affect and Mood Problems

Children and Depression

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NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

➡Background

Depressed mood is a common and universal part of human experience that can occur at any age and has various causes. Over time, many children report or give the appearance of feeling unhappy, sad, dejected, irritable, "down" or "blue" but most of them quickly and spontaneously recover from these brief and normal moods or emotional states. However, for others, the depression can be severe and long lasting, and interfere with all aspects of daily life from school achievement to social relationships.

The incidence of more severe depression in children is probably less than 10% although exact figures are not known. Girls are more likely than boys to develop mood disorders. The associated risk of suicide increases significantly during adolescence.

➡Development

Recognizing and diagnosing childhood depression is not always an easy task. The onset of depression can be gradual or sudden, it may be a brief or long term episode, and may be associated with other disorders such as anxiety. The presence of one or two symptoms is not sufficient evidence of a depressive disorder. It is when a group of such symptoms occur together over time that a more serious mood disorder should be considered. The DSM-III- R manual published by the American Psychiatric Association classified depression according to severity, duration and type.

The definition of major depression requires the presence of five or more of the following symptoms for at least two weeks. One or both of the essential features of depressed or limitable mood, and loss of interest or pleasure in almost all activities must be observed. Other symptoms include appetite disturbance and significant weight loss or gain, sleep difficulties or too much sleep, slow or agitated and restless behavior (many depressed children become overly aggressive), decreased energy or fatigue, feeling of worthlessness or self-blame and guilt, concentration and thinking difficulties, and thoughts of death or suicide.

Less severe forms of depression include dysthymia (moderately depressed mood over one year) and adjustment disorder with depressed mood caused by some known stress and lasting less than 6 months. Depressive features will vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children while adolescents are more likely to engage in antisocial behavior or become sulky, overly emotional, and withdrawn.

There are a number of suggested causes of childhood depression. Biological explanations of depression have examined the roles of hereditary, biochemical, hormonal, and brain factors. More recently, the amount of light associated with seasonal changes has been suspected to affect mood.

Psychological descriptions have linked depression to the loss of loved ones, disturbances in parent-child relationships, and threats to self-esteem. Attention has also been focused on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world.

Any of a number of psychological stressors may be able to significantly affect the mood of some children.

Given the various kinds and causes of childhood depression, there are different treatments that may be required. The "treatment" for the disappointment that follows the loss of a ball game may be a visit to the local hamburger restaurant, or the feelings of failure and irritability caused by a poor school mark could signal the need to improve study habits and pay closer attention in school. When the signs of depression described above occur and persist, the professional assistance of a psychologist or psychiatrist should be obtained. Antidepressant (tricyclics and MAO inhibitors) and antianxiety medications are very beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral, cognitive-behavioral, and interpersonal (IPT) therapy. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

➡What can I do as a parent?

The list of suggestions follows the most frequently cited symptoms of childhood depression.

—Self-esteem and self-critical tendencies: give frequent and genuine praise; accentuate the positive; supportively challenge self-criticism; point out negative thinking.

—Family stability: maintain routine and minimize changes in family matters; discuss changes beforehand and reduce worry.

—Helplessness and hopelessness: have the child write or tell immediate feelings and any pleasant aspects 3 or 4 times a day to increase pleasant thoughts over 4-6 weeks.

—Mood elevation: arrange one interesting activity a day; plan for special events to come; discuss enjoyable topics.

—Appetite and weight problems: don't force eating; prepare favorite foods; make meal-time a pleasant occasion.

—Sleep difficulties: keep regular bed-time hours; do relaxing and calming activities one hour before bed-time such as reading or listening to soft music; end the day on a "positive note."

—Agitation and restlessness: change activities causing agitation; teach the child to relax; massage may help; encourage physical exercise and recreation activities.

—Excessive fears: minimize anxiety-causing situations and uncertainty; be supportive and reassuring; planning may reduce uncertainty; relaxation exercises might help.

—Aggression and anger: convey a kind but firm unacceptance of destructive behavior; encourage the child to his angry feelings; do not react with anger.

—Concentration and thinking difficulties: encourage increased participation in games, activities, discussions; work with the teachers and school psychologist to promote learning.

—Suicidal thoughts: be aware of the warning signs of suicide; immediately seek professional help.

—if depression persists: consult your family doctor for a complete medical exam; seek a referral to a psychologist or psychiatrist.

Resources

Depression and Its Treatment—by Drs. J. H. Greist and J. Jefferson, 1984. This is a very readable layman's guide to understanding and treating depression.

Stress, *Sanity and Survival—by* Drs. R. L. Woolfolk and F. C. Richardson, 1978. Numerous suggestions are given for dealing with worry, anger, anxiety, inadequacy and other signs of stress associated with depression.

Three Steps Forward: Two Steps Back—by C. R. Swindel, 1980. Written from a religious perspective, this book offers practical ways to face problems such as loss, anxiety, self-doubt, fear and anger.

Control Your Depression—by Dr. P. Lewinsohn, 1979. This leading expert offers meaningful and helpful suggestions based on his theory of depression.

Intervention:

Behavioral Management: Suicide Crisis

In developing our Center's Resource Aid Packet on *Responding to Crisis at a School,* we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense. However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists on pages 10 and 11 are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see accompanying Suicidal Assessment Checklist). The following are some specific suggestions.

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.
- Clear the scene of those who are not needed.
- An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

Read Some More

Adolescent Suicide: Assessment and Intervention by A.L. Berman & D.A. Jobes (1991). Washington, D.C.: American Psychological Association.

Youth Suicide: A Comprehensive Manual for Prevention and intervention by B.B. Hicks (1990). Bloomington, IN: National Educational Service

SUICIDAL ASSESSMENT – CHECKLIST*

Student's Name:______________________ Date:________ Interviewer: ____________

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK – CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Assessment -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

____(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(8) Report child endangerment if necessary.

Intervention:

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled "Applying the Criteria for Empirically Supported Treatments to Studies of Psychosocial Interventions for Child and Adolescent Depression"by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.
Excerpted here are the abstract, the authors' conclusions, and their reference list.

Abstract of article by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology, 27*, 156-167.

Reviews the psychosocial treatment outcome studies for depressed children and adolescents and concludes that psychosocial interventions are effective at posttreatment and follow-up in reducing depressive symptoms/disorders in clinical and nonclinical samples of youth, regardless of treatment modality or extent of parental involvement. The article then examines the extent to which each study conforms to the guidelines set forth by the Task Force on Promotion and Dissemination of Psychological Procedures (1996) for well-established and probably efficacious interventions. Results of this analysis indicate only 2 series of studies that meet criteria for probably efficacious interventions and no studies that meet criteria for well-established treatments. Finally, the advantages and disadvantages of applying criteria for empirically supported treatments to identify good treatments for depressed youth are discussed, the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child is highlighted, and recommendations for future research that is informed by clinical practice and empirical findings are offered.

The following pages illustrate the gist of the article.

* * *

Criteria for Well-Established and Probably Efficacious Treatments

The following are the most recent criteria for ESTs (Chambless et al., 1996; see Lonigan et al., this issue). Because the child and adolescent depression intervention literature does not include a large series of single case design experiments, only criteria related to between-group design studies are delineated.

For an intervention to be deemed well established, there must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pill or psychological placebo or to another treatment, or (b) equivalent to an already established treatment in experiments with adequate statistical power ($n \geq 30$ per group). The experiments must be conducted in accordance with a treatment manual, sample characteristics must be detailed, and at least two different investigators or investigatory teams must demonstrate intervention effects. For an intervention to be classified as probably efficacious, either two experiments must demonstrate that the intervention is more effective than a wait-list condition or one or more experiments must meet all criteria for a well-established treatment, except for the requirement that treatment effects be shown by two different research teams...

...to date, none of the childhood depression intervention studies meet criteria for well-established treatments. The two studies conducted by Stark and colleagues (Stark et al., 1987, 1991), however, appear to meet criteria for probably efficacious treatments.

Because the investigations by Stark and colleagues represent the best available psychosocial treatment out-come studies for childhood depression, these studies are detailed. Stark et al. (1987) weighed the relative efficacy of 12-session group interventions involving self-control therapy, behavior problem-solving therapy, and a wait-list control for 29 fourth through sixth graders with elevated depression scores at two time points. The self-control intervention taught self-management skills (e.g., self-monitoring, self-evaluating, self-consequating, causal attributions). The behavioral problem-solving group intervention consisted of education, self-monitoring of pleasant events, and group problem solving directed toward improving social behavior. Postintervention within-group analyses found that participants in both active interventions reported fewer symptoms of depression and anxiety, whereas wait-list children reported minimal change. Between-group analyses revealed that children in the self-control condition showed relatively greater improvement in self-esteem and depressive symptoms, as measured by the Children's Depression Inventory (CDI; Kovacs, 1985), than the youth in the other two groups. However, no between-group differences were noted on the other measures of depression according to child or mother ratings or on measures of self-esteem or anxiety. At 8-week follow-up, 88% of the children in the self-control condition and 67% of the children in the behavioral problem-solving condition obtained CDI scores below the cutoff for depression (i.e., <13), and none of the participants in either experimental group met criteria for clinically significant levels of depressive symptoms according to their responses on the Children's Depression Rating Scale-Revised (CDRS-R; Poznanski, 1984). Also at follow-up, the children in the self-control condition reported greater generalization of treatment effects according to their responses to the CDRS-R and the Coopersmith Self-Esteem Inventory (Coopersmith, 1975), but no differences in depression levels were noted between the children in the self-control and behavioral problem-solving conditions on the CDI or the Child Depression Scale (Reynolds, 1989). Also, there were no between-group differences at follow-up in terms of mother's ratings of their child's depression on the Child Behavior Check-list (Achenbach & Edelbrock, 1983) or in terms of children's reports of anxiety. Taken together, results revealed that both experimental interventions were relatively successful in reducing symptoms of depression. For the most part, findings regarding the comparison of the self-control and behavioral problem-solving group interventions were equivocal. However, the pattern suggested that the self-control intervention was more beneficial to the children.

Based on results from the aforementioned study, Stark et al. (1991) evaluated an expanded version of self-control therapy for 26 fourth through seventh graders who endorsed high levels of depressive symptoms. This research offers only a partial replication of Stark's earlier work (i.e., Stark et al., 1987), as the self-control therapies tested in the two different treatment outcome studies were similar but not identical, and there was no behavioral problem-solving condition in the second study. The experimental intervention in the second study was a 24- to 26-session cognitive-behavioral treatment that consisted of self-control and social skills training, assertiveness training, relaxation training and imagery, and cognitive restructuring. This experimental treatment was compared to a traditional counseling condition designed to control for nonspecific elements of the intervention. Monthly family meetings for the cognitive-behavioral group encouraged parents to assist their children in applying their new skills and to increase the frequency of positive family activities. Monthly family sessions associated with the traditional counseling condition addressed improving communication and increasing pleasant family events. Postintervention and 7-month follow-up assessments revealed decreases in self-reported depressive symptoms for both groups of children. At postintervention, youth in the cognitive-behavioral intervention reported fewer depressive symptoms on a semistructured interview and endorsed fewer depressive cognitions.

The 1987 and 1991 outcome studies by Stark and colleagues come the closest of all of the child studies to meeting the criteria for probably efficacious treatments. Specifically, client characteristics were specified, a treatment manual was used, and two adequate group design studies demonstrated that a self-control intervention was superior to a placebo treatment. However, as noted previously, the self-control interventions used in the two studies were not identical in terms of length of treatment or material covered. With these qualifications, we view this research program as approximating that required for being a probably efficacious EST.

* * *

... The intervention research conducted by Lewinsohn and coworkers (i.e., Lewinsohn et al., 1990; Lewinsohn et al., 1996) represents state-of-the-art adolescent depression intervention research. These methodologically sophisticated studies meet criteria for probably efficacious treatments as client characteristics were specified, a treatment manual was used. and two adequate group design studies demonstrated that a coping skills program was more efficacious than a wait-list condition. Thus, a brief description of these studies is warranted. In the first study, Lewinsohn et al. (1990) randomly assigned 59 high school students, ages 14 to 18 years who met diagnostic criteria for depressive disorders, to cognitive-behavioral group treatment for the adolescent only, concurrent cognitive-behavioral treatment groups for the depressed adolescent and his or her parents, and a wait-list control condition. The cognitive-behavioral intervention, based on the Coping With Depression (CWD) course for adults, was adapted to address the concerns and competencies of adolescents. The CWD, a 14-session multiple component intervention, focuses on experiential learning and skills training, with attention to increasing pleasant activities, training in relaxation, controlling depressive thoughts, improving social interaction, and developing conflict resolution skills. The seven-session complimentary parent intervention program is designed to enhance parents' ability to reinforce their adolescent's adaptive changes, which should increase the maintenance and generalization of treatment effects. Postintervention assessment indicated that fewer adolescents in the two active treatment groups met diagnostic criteria for depression as compared to youth in the wait-list group. Also, compared to their nontreated counterparts, adolescents in the CWD adolescent-only and the CWD for adolescent-and-parent evidenced greater reductions in self-reported depressive and anxious symptoms and maladaptive cognitions and evidenced more involvement in positive events. Treatment gains were maintained at 2-year follow-up. Although there were a few statistically significant differences between the adolescent-only CWD condition and the adolescent-and-parent CWD, no between-group differences were found on most variables, suggesting either that the outcome was similar for both groups or that with a larger sample, the adolescent-and-parent CWD would prove to be more effective than the adolescent-only condition.

The second study conducted by Lewinsohn et al. (1996) was a replication, with modifications, of the prior design. Skills training was interwoven throughout the CWD course rather than offered in single blocks in separate sessions. The other modification was the addition of random assignment to different conditions during the 2-year follow-up phase: (a) booster sessions plus assessment every 4 months, (b) assessment only every 4 months, and (c) annual assessment only. In a sample of 96 adolescents meeting diagnostic criteria for major depressive disorder or dysthymic disorder, recovery rates in the two active treatment conditions (i.e., CWD = 65%, CWD plus parent intervention = 69%) were greater than those for the adolescents in the wait-list control group (48%). No significant differences were found between the two experimental groups. Comparable recovery and relapse rates were reported for the three follow-up conditions. Of particular interest was that at the 2-year follow-up, 97.5% of adolescents who participated in an active treatment condition no longer met criteria for a depressive disorder.

Current Empirical Status of Psychosocial Interventions for Depressed Children and Adolescents

In summary, results from this review reveal that several psychosocial intervention programs, the majority of which are based on a cognitive-behavioral model, are effective in reducing depressive symptoms and alleviating depressive disorders in nonclinical samples of children and both clinical and nonclinical samples of adolescents. Positive treatment effects are noted regardless of treatment modality (group, individual, or family therapy) or nature or extent of parental involvement. Treatment effects generally are maintained at follow-up. However, because most of the studies were conducted in schools with nonreferred youth with depressive symptoms and used relatively inexperienced clinicians, the generalizability of the findings across populations, settings, and clinician-experience level remains unclear. Further, because few between-group design studies have compared different interventions, it is premature to conclude that any specific intervention approach is most efficacious in reducing depression in youth. Given that the intervention literature on mood disorders in youth is in its infancy and most of the studies were conducted prior to the establishment of the criteria for ESTs, it is not surprising that none of the interventions met criteria for well-established treatments and only one series of child studies and one series of adolescent studies appear to meet the criteria for probably efficacious interventions.

Strengths and Weaknesses of the EST Approach

Our review of the child and adolescent depression treatment literature brings to the fore a number of advantages and disadvantages of the EST movement. There are enumerable methodological advantages to ascertaining the efficacy of an intervention based on its superiority to a pill, placebo, or other treatment or its equivalence to an already established treatment when a random assignment to control study is conducted. Only with random assignment can between-group differences in the reduction of depression and its sequelae be attributed to the intervention. However, a major clinical concern often emerges regarding random assignment to a placebo control condition. Some youth with significant problems (e.g., suicidal ideation) will not receive adequate and timely care in the control condition. Many researchers have handled this issue by eliminating children with elevated levels of suicidal ideation. This, however, limits the utility of the interventions to those depressed youth in greatest need.

The primary advantages of conducting treatments in accord with a manual are that such interventions (a) are systematic, focused, and goal-oriented; (b) enable more mental health professionals to be trained to provide effective psychosocial interventions for depressed youth; (c) increase our ability to detect differences between treatment conditions; and (d) have a greater likelihood for replication. A number of obstacles impede the use of treatment manuals for addressing child and adolescent depression. First, rigid application of a manualized treatment protocol may result in difficulty establishing rapport with a depressed youth and ineffective dissemination of psychological services due to the therapist's inability to attend to the distinctive mood or context of each session or the child's current concerns. Second, it is difficult for an intervention manual to address individual differences (e.g., depression symptoms and severity, comorbid conditions, education level, cognitive level, age, sex, family constellation, family income, attendance patterns). Third, most treatment manuals only address a singular problem (e.g., depression) rather than the comorbid psychological conditions and environmental influences (e.g., poverty, physical/sexual abuse, parent and child substance abuse and psychiatric problems, parental cognitive limitations) that impact the child's adjustment and that often are of greater concern to the child or family than the child's depression. Finally, most treatment manuals lack systematic attention to the child's background (e.g., ethnicity, income level), belief system, and expectations of therapy.

The key advantage of specifying client characteristics is that this information is crucial to considerations regard-ing the generalizability of the findings. There are no disadvantages to informing the reader of the client character-istics. However, the issue of determining client characteristics for inclusion criteria often is a challenging one. Developing inclusion criteria comprehensive enough to promote participation of all youth who need the intervention results in considerable within-group variability. It is difficult to control for this variability when matching the experimental and control groups. Many researchers address this dilemma by providing relatively narrow inclusion criteria, which limits the generalizability of findings from research studies to actual clinical practice. Often treatment outcome researchers, in an effort to conduct methodologically sophisticated studies, place methodological rigor above clinical reality.

The merits of determining the efficacy of an intervention across research teams are without question, and there are no disadvantages of such a recommendation. The dilemma for researchers in achieving this goal is the limited research funding available for conducting psychosocial intervention studies for depressed youth.

A Look to the Future

In closing, a number of problems with the child and adolescent depression treatment literature are noteworthy and have implications for the development and implementation of future treatment outcome studies. First, most studies failed to accommodate developmental differences in children's competencies and did not assess the benefits of various intervention strategies for youth at different ages and developmental levels. The protocols often failed to incorporate the pertinent developmental psychology literature on cognitive and affective development, but rather appeared to be downward extensions of adult depression interventions. Thus, future research should integrate developmental research findings on the cognitive, affective, and social functioning of youth in devising and implementing therapies for depressed children and adolescents. Given that children are embedded within a family context, a developmental perspective also highlights the importance of active family involvement, including family therapy (Kaslow & Racusin, 1994).

A second problem is the lack of a culturally sensitive perspective. Most studies were conducted with middle-class, Caucasian youth, and little attention was paid to the cultural relevance of the materials used, the intervention strategies incorporated, and the cultural background and sensitivity of the therapists who administer the protocols. Thus, in the future, researchers should include diverse groups of children, the therapists should be cognizant of the child's sociocultural context and aware of their own ethnicity affects the therapeutic alliance, and culturally sensitive assessment and interventions should be incorporated.

Third, there are no data that indicate which treatments are most effective for which depressed children and adolescents, and none of the investigatory teams have examined which specific component(s) of the multifaceted interventions is most beneficial for which children. Future studies would be more informative if they examined which children benefitted most from which intervention components (e.g., social skills training, cognitive restructuring, family involvement).

This would help clinicians to target specific intervention components for different children and families. In addition, researchers need to ascertain which depressed children are most likely to benefit from cognitive-behavioral versus interpersonal versus family therapy versus pharmacology, or some combination thereof. Such information will enable clinicians and clinical researchers to provide the optimal treatment for each depressed child or adolescent.

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Intervention:

PSYCHOTROPIC MEDICATIONS
CATEGORIZED BY CHILD /ADOLESCENT DIAGNOSIS*

This chart provides some brief information on psychotropic medications frequently prescribed for students. The medications are listed with respect to the diagnosis that leads to their prescription. For more information, see the *Physicians Desk Reference.*

IV. Diagnosis: Bipolar Disorder

Medication Types and Treatment Effects

A. Anti-manic

Used to reduce frequency and intensity of manic episodes. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgement, aggressiveness, and possibly hostility.

B. Anti-convulsant

Approved to treat various seizure types among those tat least 6 years of age. Carbamazepine is regarded as most beneficial for persons diagnosed with partial seizures with complex symptomatology (psychomotor or temporal lobe), but those with generalized tonic-clonic seizures or a mixed seizure pattern also may benefit (Green, 1995)

References

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Names: Generic (Commercial)	**Some Side Effects and Related Considerations**
A. Anti-manic	
lithium carbonate/citrate [Lithium, Lithane, Lithobid, ithotabs, Lithonate, Eskalith Cibalith	Safety and effectiveness have not been established for those under 15 years of age. May manifest tremor, drowsiness, dizziness, nausea, vomiting, fatigue, irritability, clumsiness, slurred speech, diarrhea. increased thirst, excessive weight gain, acne, rash. Serum levels must be monitored carefully because of therapeutic dose is close to toxic level. Care must be taken to maintain normal fluid and salt levels.
B. Anti-convulsants	
Carbamazepine [Tegretol, Mazepine, Epitol]	May manifest drowsiness, dizziness, fatigue, coordination problems, respiratory depression, edema, nausea, vomiting, hepatitis, nystagmus, and various negative effects associated with trycyclic antidepressants. Parents are instructed to withhold and notify physician immediately if signs of toxicity (e.g., anorexia, fever, unusual fatigue, bruising, bleeding). Females using oral contraceptives are informed that reliability of contraceptive may be reduced.
Valproic acid [Depakene]	Most serious side effect is hepatic failure which can be fatal. It occurs most frequently within the first six months of treatment. Children under two years of age are at increased risk; the risk of hepatoxicity decreases considerably as patients become progressively older. Hence, liver function must be monitored carefully and frequently, especially during the first six months. Nausea, vomiting, and indigestion may occur early in treatment and usually are transient. Sedation may occur, and untoward psychiatric effects such as emotional upset, depression, psychosis, aggression, hyperactivity, and behavioral deterioration have been reported.

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* See references in previous excerpted articles.

Agencies and Online Resources Relevant to Affect and Mood Problems

American Association of Suicidology

The American Association of Suicidologyn is a nonprofit organization dedicated to the understanding and prevention of suicide. This site is designed as a resource for anyone concerned about suicide, including AAS members, suicide researchers, therapists, prevention specialists, survivors of suicide, and people who are themselves in crisis.

Contact: Alan L. Berman, Ph.D., Executive Director, 4201 Connecticut Avenue, N.W. Suite 310 Washington, DC 20008 Voice: (202) 237-2280 Fax: (202) 237-2282
E-Mail: amyjomc@ix.netcom.com Web: http://www.cyberpsych.org/aas/index.html

Center for Suicide Research and Prevention

Rush-Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 995, Chicago, IL 60612 Voice (312) 942-7208 Fax: (312) 942-2177

D/ART: Depression/Awareness, Recognition and Treatment

(D/ART), DEPRESSION; Awareness, Recognition, and Treatment is a federal government program to educate the public, primary care providers, and mental health specialists about depressive illnesses--their symptoms, diagnosis, and treatment. Sponsored by the National Institute of Mental Health (NIMH) and based on more than 50 years of medical and scientific research, D/ART is a collaboration between the government and community organizations to benefit the mental health of the American public.

Contact: D/ART, 5600 Fishers Lane, Rockville, MD 20857 Phone: 1-800-421-4211
Website: http://www.nimh.nih.gov/dart/index.htm

Depression Resource List

An easy to use site with lists of resources online related to depression, suicide, manic depression, panic and anxiety and treatment. Several support group websites listed for each topic.

Email: corbeau@execpc.com Web: http://www.execpc.com/~corbeau/

Depression.com

The editorial staff of Depression.com screens the latest news and research, reviews the dozens of depression-related sites in cyberspace, and provides an interactive forum for people who deal with it. Also provides quizzes and numerous topics filled with information about depression.

Website: http://www.depression.com/

DRADA (Depression and Related Affective Disorders Assn)

DRADA's mission is to alleviate the suffering arising from depression and manic depression by assisting self-help groups, providing education and information, and lending support to research programs. DRADA works in cooperation with the Department of Psychiatry at the Johns Hopkins University School of Medicine, which helps us ensure that our materials are medically accurate, as well as co-sponsoring our annual mood disorders research/education symposiums.

Contact: 600 N. Wolfe St., Baltimore, MD 21287-7381
Phone: (410) 955-4647 or (202) 955-5800 FAX: (410) 614-3241
Email:drada@welchlink.welch.jhu.edu Website: http://www.med.jhu.edu/drada/

National Depressive and Manic-Depressive Association

The mission of the National Depressive and Manic-Depressive Association is to educate patients, families, professionals, and the public concerning the nature of depressive and manic-depressive illness as treatable medical diseases; to foster self-help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses.

Contact: 730 N. Franklin, #501, Chicago, IL 60610 Phone: 800-826-3632 or (312) 42-0049;
FAX: (312)642-7243. Website: http://www.ndmda.org/

MDSG-NY (Mood Disorders Support Group, Inc.)

This site is Internet's central clearing house for information on all types of depressive disorders and on the most effective treatments for individuals suffering from Major Depression, Manic-Depression (Bipolar Disorder), Cyclothymia, Dysthymia and other mood disorders.

Contact: P.O. Box 1747, Madison Square Station, New York, NY 10159
Phone: (212) 533-MDSG; FAX: (212) 475-5109. Website: http://www.psycom.net/mdsg.html

Pendulum Resources

One of the oldest mailing lists for bipolar disorder also has a Web site which is a comprehensive resource on mood disorders, covering all aspects of this topic through a variety of resources including articles, online support groups, humor.

Email: webmaster@pendulum.org Website: http://www.pendulum.org/

The Samaritans

A non-religious charity that has been offering emotional support to the suicidal and despairing for over 40 years by phone, visit and letter. Callers are guaranteed absolute confidentiality and retain the right to make their own decisions including the decision to end their life. The service is available via E-mail, run from Cheltenham, England, and can be reached from anywhere with Internet access. Trained volunteers read and reply to mail once a day, every day of the year.

Contact: 10 The Grove, Slough, Berkshire SL1 1QP
Phone: 01753 216500 Fax: 01753 775787
Email: jo@samaritans.org Website: http://www.samaritans.org.uk/

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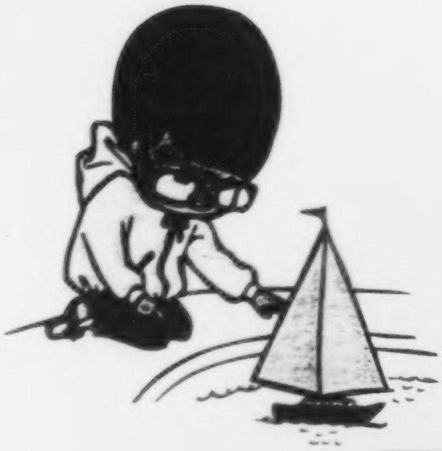

Contents of Section III E:

Social and Interpersonal Problems

Overview

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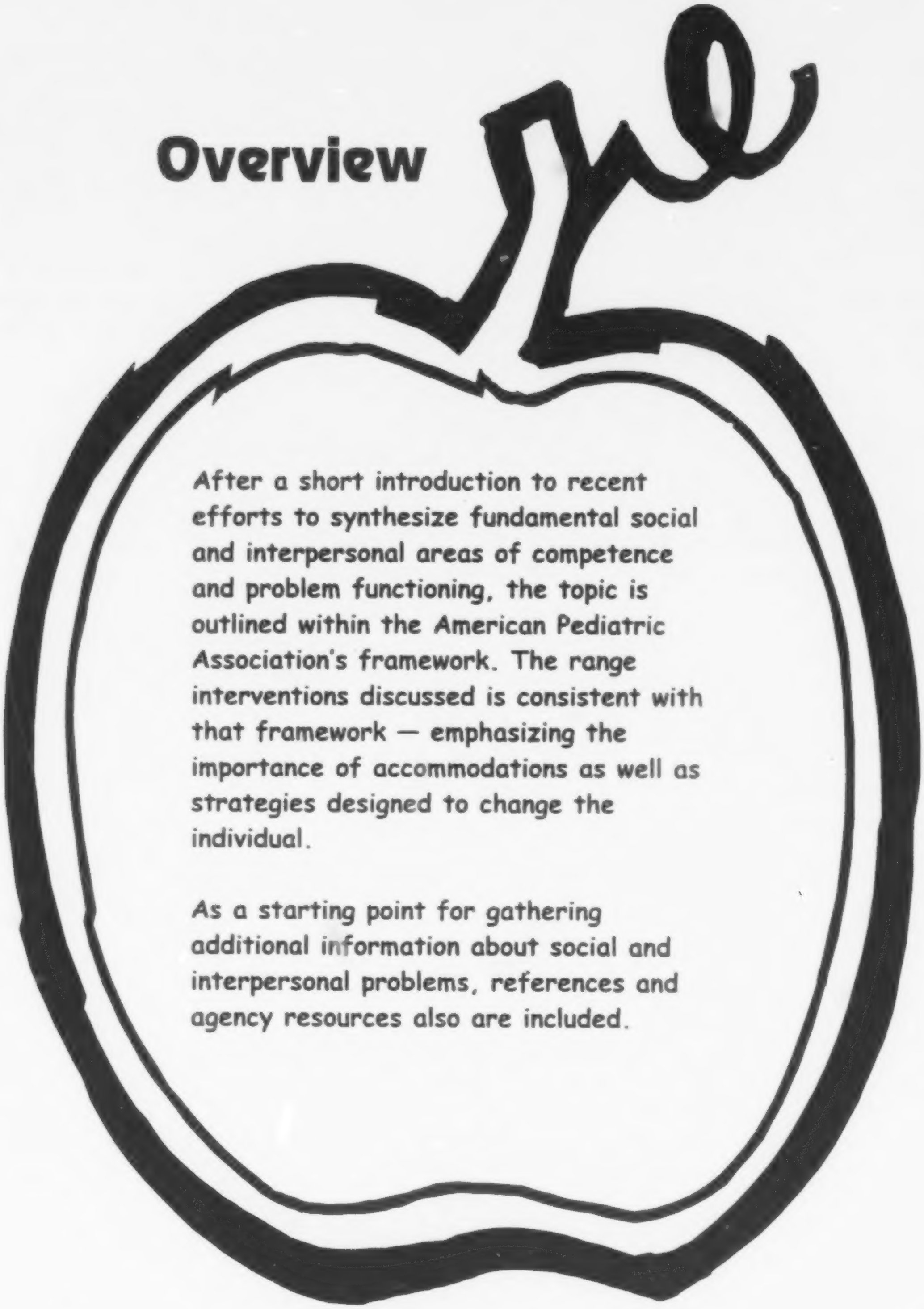
5. A Few References and Other Sources of Information

Overview



After a short introduction to recent efforts to synthesize fundamental social and interpersonal areas of competence and problem functioning, the topic is outlined within the American Pediatric Association's framework. The range interventions discussed is consistent with that framework — emphasizing the importance of accommodations as well as strategies designed to change the individual.

As a starting point for gathering additional information about social and interpersonal problems, references and agency resources also are included.

Adapted from the School Mental Health Project/
Center for Mental Health in Schools – UCLA
Newsletter: Addressing Barriers to Learning,
Vol. 2 (2), Spring, 1997

Social and Emotional Functioning

There are no sound data on the scope of children's social and interpersonal problems. It is clear, however, that youngsters who have difficulty establishing or maintaining or ending interpersonal relationships are of major concern to teachers and parents. Problems in this area are associated with poor performance at school -- including a range of behavioral, learning, and emotional problems.

With the burgeoning of programs focused on preventing and correcting social and emotional problems, it helps to have a synthesis of fundamental areas of concern. W.T. Grant Foundation (in the 1980s) funded a five year project that brought together a consortium of professionals to review the best programs and create such a synthesis.* The following is their list of core social and emotional competence:

Emotional

- identifying and labeling feelings
- expressing feelings
- assessing the intensity of feelings
- managing feelings
- delaying gratification

Cognitive

- self-talk -- conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior
- reading and interpreting social cues -- for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community
- using steps for problem-solving and decision-making -- for instance, controlling impulses, setting goals, identifying alternative actions, anticipating consequences
- understanding the perspectives of others
- understanding behavioral norms (what is and is not acceptable behavior)
- a positive attitude toward life
- self-awareness -- for example, developing realistic expectations about oneself

Behavioral

- nonverbal -- communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
- verbal -- making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

The W. T. Grant consortium list is designed with prevention in mind. It can be compared and contrasted with frameworks suggested for training children manifesting behavior problems. Below is the set of skills prescribed by M.L. Bloomquist (1996) in *Skills Training for Children with Behavioral Disorders.* After stressing the importance of (a) increased parental involvement, (b) greater use of positive reinforcement, and (c) enhanced positive family interaction skills, Bloomquist details the following as areas parents should focus on with their children.

- compliance (listening and obeying adults' directives)
- following rules (adhering to formal rules)
- social behavior skills (making and keeping friends)
- social and general problem-solving skills (stopping and thinking before working on a problem, thinking and doing in a step-by-step manner)
- coping with anger (stopping outbursts)
- self-directed academic behavior skills (organizing work, budgeting time, self-monitoring and staying on task, using study skills)
- understanding and expressing feelings (increasing one's "feelings vocabulary," observing and practicing awareness and expression of feelings)
- thinking helpful thoughts (identifying one's negative thoughts, understanding how they influence one's emotions, strategies to change negative thoughts in order to experience more positive emotions)
- self-esteem (coming to evaluate oneself positively as a result of developing skills, experiencing positive feedback, and positive family interactions)

*W.T. Grant Consortium on the School-Based Promotion of Social Competence (1992). Drug and alcohol prevention curriculum. In J.D. Hawkins, et al. (Eds), *Communities that Care*. San Francisco: Jossey-Bass.

1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Social Interaction Variation

Because of constitutional and/or psychological factors, children and adolescents will vary in their ability and desire to interact with other people. Less socially adept or desirous children do not have a problem as long as it does not interfere with their normal development and activities.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Infants exhibit a variety of individual differences in terms of reactivity to sensation (underreactive or overreactive), capacity to process information in auditory, visual modes, as well as motor tone, motor planning, and movement patterns. For example, some babies are underreactive to touch and sound, with low motor tone, and may appear self-absorbed and require a great deal of parental wooing and engagement to be responsive. The ease with which the caregivers can mobilize a baby by dealing with the infant's individually different pattern suggests a variation rather than a problem or disorder.

Early Childhood
The child is self-absorbed, enjoys solitary play, with and without fantasy, but can be wooed into relating and interacting by a caregiver who tailors his or her response to individual differences. The child may be sightly slower in his or her language development and not make friends easily.

Middle Childhood
The child may not make friends easily and be less socially adept. The child may prefer solitary play at times.

Adolescence
The adolescent has limited concern regarding popular dress, interests, and activities. The adolescent finds it difficult to make friends at times.

SPECIAL INFORMATION

Consider expressive language disorder or mixed receptive-expressive language disorder

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* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM

Social Withdrawal Problem

The child's inability and/or desire to interact with people is limited enough to begin to interfere with the child's development and activities.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
The infant has an unusually high threshold and/or low intensity of response, is irritable, difficult to console, overly complacent may exhibit head banging or other repetitive behavior. The infant requires persistent wooing and engagement, including, at times, highly pleasurable and challenging sensory and affective experiences, to keep from remaining self-absorbed and withdrawing.

Early Childhood
The child shows self-absorption, and prefers solitary play. The child has some verbal and/or nonverbal communication, is mildly compulsive, and shows rigid behaviors.

Middle Childhood
The child is very shy, reticent, shows an increased concern about order and rules, is socially isolated, rarely initiates peer interactions, and prefers solitary activities to peer group activities.

Adolescence
The adolescent shows difficulty in social situations, has limited friendships, is socially isolated, may be a ''loner,' prefers solitary activities to peer group activities, is reticent, has eccentric hobbies and interests, and has limited concern regarding popular styles of dress, behavior, or role models.

SPECIAL INFORMATION

Consider sensory impairments (vision, hearing).

Excessive sensory stimulation may increase anxiety and agitation.

There are children with initial symptoms severe enough to be considered as having an autistic disorder, who with appropriate and full intervention, will markedly improve.

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care.* (1996) American Academy of Pediatrics

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)*

Diagnostic criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood, and present in a variety of contexts, as indicated by four (or more) of the following:

(1) avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

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*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care.* (1996) American Academy of Pediatrics

Avoidant Personality Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

DIAGNOSTIC FEATURES

The essential feature of Avoidant Personality Disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts. Individuals with Avoidant Personality Disorder avoid work or school activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Criterion 1). Offers of job promotions may be declined because the new responsibilities might result in criticism from co-workers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism (Criterion 2). Until they pass stringent tests proving the contrary, other people are assumed to be critical and disapproving. Individuals with this disorder will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, have difficulty talking about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed (Criterion 3).

Because individuals with this disorder are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions (Criterion 4). If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited and "invisible" because of the fear that any attention would be degrading or rejecting They expect that no matter what they say, others will see it as "wrong," and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision. Despite their longing to be active participants in social life, they fear placing their welfare in the hands of others. Individuals with Avoidant Personality Disorder are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem (Criterion 5). Doubts concerning social competence and personal appeal become especially manifest in settings involving interactions with strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others (Criterion 6). They are unusually reluctant to take personal risks or to engage in any new activities because these may prove embarrassing (Criterion 7). They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. Someone with this disorder may cancel a job interview for fear of being embarrassed by not dressing appropriately. Marginal somatic symptoms or other problems may become the reason for avoiding new activities.

ASSOCIATED FEATURES AND DISORDERS

Individuals with Avoidant Personality Disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being "shy," timid," "lonely," and "isolated." The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement.

Other disorders that are commonly diagnosed with Avoidant Personality Disorder include Mood and Anxiety Disorders (especially Social Phobia of the Generalized Type). Avoidant Personality Disorder is often diagnosed with Dependent Personality Disorder, because individuals with Avoidant Personality Disorder become very attached to and dependent on those few other people with whom they are friends. Avoidant Personality Disorder also tends to be diagnosed with Borderline Personality Disorder and with the Cluster A Personality Disorders (i.e., Paranoid, Schizoid, or Schizotypal Personality Disorders) .

SPECIFIC CULTURE, AGE, AND GENDER FEATURES

There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following immigration. This diagnosis should be used with great caution in children and adolescents for whom shy and avoidant behavior may be developmentally appropriate. Avoidant Personality Disorder appears to be equally frequent in males and females.

PREVALENCE

The prevalence of Avoidant Personality Disorder in the general population is between 0.5% and 1.0%. Avoidant Personality Disorder has been reported to be present in about 10% of outpatients seen in mental health clinics.

COURSE

The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of Avoidant Personality Disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals who go on to develop Avoidant Personality Disorder may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults Avoidant Personality Disorder tends to become less evident or to remit with age.

4. Interventions

On the following pages are discussions of

- **Accomodations to Reduce Social and Interpersonal Problems**
- **Behavior Management and Self Instruction**
- **Empirically Supported Treatments for Social and Interpersonal Problems**

Intervention:

Accommodations to Reduce Social and Interpersonal Problems

Excerpts from:

Creating a Districtwide Social Development Project

Roger P. Weissberg, Timothy P. Shriver, Sharmistha Bose, and Karol DeFalco
published in *Educational Leadership May 1997*

. . . In the New Haven, Connecticut, public schools, we have found that *sustained* efforts to enhance children's social and emotional development can help students become knowledgeable, responsible, and caring citizens (Elias et al. in press). This positive approach promotes competence—and it prevents many high-risk behaviors. For the past 10 years, we have continued to develop this program and have enhanced students' academic performance, social competence, and health.

Task Force Findings

. . . The New Haven task force noted that the same students experienced several problems simultaneously—problems that seemed to have common roots, such as poor problem-solving and communication skills; antisocial attitudes about fighting and education; limited constructive after-school opportunities; and a lack of guidance and monitoring by adults who are positive role models. The task force recommended that New Haven create a comprehensive K-12 social development curriculum to address these needs.

The Social Development Project

The superintendent and board of education established a district-level Department of Social Development— with a supervisor and staff of facilitators—that coordinated all prevention and health-promotion initiatives. The department ensured broad, representative, ongoing involvement by school staff, parents, and community members in establishing coordinated social and emotional education opportunities for all students—in regular, special, and bilingual education.

The goals are to educate knowledge-able, responsible, and caring students who acquire a set of basic skills, values, and work habits for a lifetime of meaningful work and constructive citizenship. Other goals include helping students develop positive self-concepts and helping them learn to live safe, legal, and healthy lives.

Curriculum objectives and content. Curriculum committees at all grade levels developed a K-12 scope and sequence for the Social Development curriculum. . . . Throughout the process, the committees considered federal standards, state mandates, and the priorities of local educators, parents, community members, and students; and they obtained the support of university psychologists.

Over a period of five years, New Haven phased in the new curriculum, with 25-50 hours of instruction at each grade. The curriculum emphasizes the following:

- Self-monitoring, problem solving, conflict resolution, and communication skills.
- Values such as personal responsibility and respect for self and others.
- Content about health, culture, interpersonal relationships, and careers.

. . . .

Professional development. The Department of Social Development established professional development programs to support and train teachers, administrators, and pupil personnel staff who implement these programs. Master teachers and coaches are the core of this effort, as they help coordinate classroom instruction with school and community programming. In this ongoing program, teachers bring their successes and challenges back to the group. . . .

Program evaluation. Finally, the department designed monitoring and evaluation strategies to assess the effectiveness of the program and to identify ways to improve it. . . . research has demonstrated positive effects on students' problem-solving skills, attitudes about conflict, impulse control, social behavior, delinquency, and substance use (Weissberg et al. 1997, Caplan et al. 1992, Kasprow et al. 1991).

Recommendations

. . .

- School-based prevention programs should embrace a broad conceptualization of health and positive youth development, addressing children's social, emotional, and physical health through coordinated programming.
- Programs should offer develop-mentally appropriate, planned, sequential K-12 classroom instruction, using culturally relevant information and materials.
- Effective prevention involves teaching methods that ensure active student engagement, emphasize positive behavior change, and improve student-adult communication. Students are more likely to benefit when they are encouraged to apply skills to real-life situations and to learn effective communication skills.
- Peers, parents, the school, and community members should work together to reinforce classroom instruction.
- Team members must design programs that are acceptable to and reach students at risk, including students already engaging in risky behaviors. Classroom instruction must be better coordinated with social, mental health, and health services that are provided to high-risk youth.
- Districts must develop system wide practices and infrastructures to support social and emotional devolopment programs.

. . . Healthy social and [illegible] learning goes beyond the prevention of specific negative outcomes. We need to abandon piecemeal approaches to prevention; we must provide supportive, creative, and caring learning environments to nurture the healthy development of children.

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Intervention:

Accommodations to Reduce Social and Interpersonal Problems

Shyness

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SCHOOL
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➤ Background

Most people have felt shy at some time or in some situation. As many as 25% of high school and college students report having been shy most of their lives (Schwartz & Johnson, 1985). Excessive shyness, however, reduces both the amount and quality of social interactions a child has with others and results in lowered peer acceptance and fewer opportunities to acquire social skills. It is not clear why some children are bashful and withdrawing whereas others tend to be more outgoing. Several factors may be involved, including genetics, temperament, anxiety, and lack of social skills.

➤ Development

Some degree of shyness in children is to be expected and is part of the child's normal development (Berk, 1989). A fairly high percentage of preschoolers are described as bashful and avoiding contact with others (Schwartz & Johnson, 1985). Between 30% and 50% of school-age children report feeling shy (Peterson, 1987). When shyness is experienced by the child in many or most situations over an extended period of time, interventions to help the child interact more appropriately are called for. Chronic and severe shyness can have a negative impact on social, emotional, and academic development. Shy children often have poor self-concept, feelings of failure, and make negative self-statements. The anxiety that accompanies shyness impairs memory and concentration and may keep children from asking for needed help in school.

➤ What Can I Do as a Parent?

It will be important for your child to learn ways to reduce his or her anxiety in social situations. If the child does not possess the social skills needed to interact with others, it may be necessary to teach social skills directly. The child also needs to learn to feel better about himself or herself as a person. There are many ways to accomplish these goals. Make sure your child knows that they are loved and valued regardless of their behavior or performance. Talk with your child, about their experiences and help them to evaluate those experiences in nonjudgmental ways that allow them to feel good about themselves. Many times children judge themselves much more harshly than we realize and blame themselves for situations and events they cannot control.

As a parent, you can give your child more independence and opportunities to demonstrate responsibility. Successful handling of independence and responsibility will help to foster an improved self-image. A child's image of himself or herself is built on a foundation of many small experiences. The more of those that demonstrate to the child that they possess the capability to succeed, the better the resulting self-image will be.

Parents can seek out and provide activities that will allow the child to experience success in social environments. Structured group activities or small groups of one or two other children may facilitate success for the shy child. Parents can discuss, rehearse, and role-play activities with children such as introducing oneself, asking a peer to play, or joining a group of children who are playing a game. If the child is involved in a social-skills training program, parents can reinforce targeted social skills and provide opportunities for rehearsal of skills.

If your child is severely shy and inhibited in most situations, the best course of action may include seeking professional help, either through the school, local mental health agency, or your family physician. Severe shyness affects many aspects of the child's life and should not be left unaddressed.

➤ What Can I Do as a Teacher?

Shy children may be easily overlooked in a busy classroom because they do not present classroom management problems and usually comply with instructions. Teachers need to be sensitive to the needs of shy children and facilitate their interaction with others and their participation in the class. Because shy children are often characterized by anxiety, it is best to avoid drawing attention to them or putting them in situations that will require that they be the center of attention. Structured interactions and small group activities may best facilitate participation by shy students. When children are to work on projects in small groups, the teacher should form the groups rather than allowing students to group themselves. Teachers can take this opportunity to pair shy youngsters with socially competent students who will serve as models for them.

Teachers need to avoid reinforcing shy behavior, to be sensitive to the needs of shy children but to refrain from giving the shy child special attention or privileges. When shy children interact appropriately that is the behavior that should be reinforced. There is a natural tendency to either ignore or be overly protective of shy children, but neither of these responses benefits the child. Shy children should be encouraged to interact, provided with opportunities to interact in small, structured settings, and reinforced for interacting. Direct social-skills training and contingency management procedures have been found to produce positive results and may be beneficial for the entire class.

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Intervention:

Accommodations to Reduce Social and Interpersonal Problems

Enhancing Motivation and Skills in Social Functioning

Adelman, H. S., and Taylor, L. (1993).
Learning Problems & Learning Disabilities: Moving Forward (pp. 362-364).
Pacific Grove, CA: Brooks/Cole Publishing Co.

Persons with learning disabilities and other learning problems often do not behave in ways others think they should. The behavior of such persons has been labeled behavior problems, misbehavior, adaptive behavior deficits, lack of social skills, and so forth. (Public Law 94-142 specifically requires assessment of "adaptive" behavior.) Recently, there has been a trend to view these behavior "problems" as an indication of immature social development, especially a lack of skills for interpersonal functioning and problem solving. This has led to a variety of "social skills training" programs.

How promising are programs for training social skills? Recent reviewers have been cautiously optimistic about the potential value of several proposed approaches. At the same time, there is concern that such skill training seems limited to what is specifically learned and to the situations in which the skills are learned. Moreover, the behaviors learned seem to be maintained for only a short period after the training. These concerns have been raised in connection with (1) training specific behaviors, such as teaching a person what to think and say in a given situation, and (2) strategies that emphasize development of specific cognitive or affective skills, such as teaching a person how to generate a wider range of options for solving interpersonal problems.

As with other skill training strategies, the limitations of current approaches seem to result from a failure to understand the implications of recent theory and research on human motivation. It is evident that many social skill training programs lack a systematic emphasis on enhancing participants' motivation to avoid and overcome interpersonal problems and to learn and continue to apply interpersonal skills to solve such problems.

In keeping with the ideas presented in Part 3, we have been exploring ways to engage a student initially in a variety of activities intended to overcome or minimize avoidance and enhance positive motivation for improving social functioning, especially the solving of interpersonal problems. The general assumptions underlying this work are discussed in Chapters 8 through 11. In addition, with regard to social functioning, we assume that

1. not all problems with social functioning are indications that a person lacks social skills
2. assessment of social skill deficiencies is best accomplished after efforts are made (a) to minimize environmental factors causing interpersonal problems and (b) to maximize a student's motivation for coping effectively with such problems
3. regular teaching and remedial strategies to improve skills for social functioning are best accomplished in interaction with systematic strategies to enhance motivation (a) for avoiding and overcoming interpersonal problems and (b) for continuing to apply social skills

The specific steps we have developed so far to address major motivational considerations in overcoming interpersonal problems are outlined in Feature 1. Steps in enhancing skills are outlined in Feature 2.

Because we have not addressed the topic of social skills in any depth in the text, a few words about the steps outlined in Feature 1 seem in order. The interest in training social skills has resulted in a rapidly growing body of literature specifying skills and procedures (see references at the end of Chapter 11). Although most social skills curricula await further evaluation, we have drawn upon available work to arrive at what appears to be a promising synthesis of "skills" and practices. Furthermore, our approach to teaching the skills uses a general problem-solving sequence. In essence, individuals are taught to (1) analyze interpersonal problem situations, (2) generate and evaluate a range of options and specific steps for resolving problems, and (3) implement and evaluate the chosen option, and then (4) if necessary, select another alternative.

These abilities can be practiced as lessons or when natural interpersonal problems arise in the classroom. For those who are interested and capable, the problem-solving framework itself can be taught. When formal lessons are used, small-group instruction is favored because it provides a social context for learning about social matters; however, individuals should be given private lessons when necessary. We propose that groups meet each day for 30-45 minutes over a period of about eight weeks.

For each step, three guidelines shape the choice of specific instructional objectives. Recognizing that both motivational and developmental readiness must be accommodated, the guidelines stress the following:

- Not teaching previously learned skills or those that the individual does not want to pursue currently. (In such instances, scheduled lessons are replaced by enrichment activities; needed skills instruction is postponed until sufficient interest can be established.)

- Teaching the skills most needed in pursuing current relationships. (Lessons are not necessarily presented in the order listed in Feature 2.) Optimally, objectives are keyed to match the individual's current needs. Such needs are identified by the individual involved or by school personnel who have assessed the deficiencies by closely observing well-motivated attempts at solving interpersonal problems.

- Developing missing prerequisites for learning and performing needed skills. When necessary, individuals are involved in additional exercises to improve (1) communication, (2) divergent thinking, (3) recognition and understanding of individual differences, and/or (4) understanding the value of respect and concern for others.

Feature 1 Initial Steps for Enhancing and Maintaining Motivation to Solve Interpersonal Problems

Activities such as direct discussions, responding to direct questions, sentence completion, or Q-sort items, role playing, audiovisual presentations,* and so on are used as vehicles to present, elicit, and clarify

1. specific times when the individual experiences interpersonal problems (without assigning blame)
2. the form of the problems (again, no judgments are made)
3. the individual's perceptions of the causes of the problems**
4. a broader analysis of possible causes (the individual's thoughts about other possible reasons and about how other people might interpret the situation; intervener examples of other perceptions and beliefs)
5. any reasons the individual might have for wanting the interpersonal problems not to occur and for why they might continue
6. a list of other possible reasons for people not wanting to be involved in such problems
7. the reasons that appear personally important to the individual and why they are significant, underscoring the individual's most important reasons for wanting not to be involved in such problems
8. general ways in which the individual can deal appropriately and effectively with such problems (avoid them; use available skills; develop new skills)
9. the individual's (a) general desire not to continue to experience interpersonal problems, (b) specific reasons for wanting this, and (c) desire to take some action
10. the available alternatives for avoiding problems, using acquired skills, and developing new skills
11. the available options related to activities and objectives associated with learning new skills (the specific activities and materials, mutual expectations, and so on)
12. specific choices stated as a mutually agreeable plan of action for pursuing alternatives clarified in steps 10 and 11.

Any step can be repeated as necessary (perhaps because of new information). Also, once the skill development activities are initiated, some of the steps must be repeated in order to maintain an individual's motivation over time.

*Videotapes are particularly useful to make points vividly (to portray others in comparable situations, to present others as models). **Each step does not require a separate session (for example, steps 1 through 3 can be accomplished in one session).

Feature 2 Steps to Enhance Skills for Solving Interpersonal Problems

1. Presentation of examples of interpersonal problem solving (read by the instructor using visual aids or a videotape presentation).*

2. Group discussions of examples stressing (a) why the person in the example wanted to solve the problem, (b) the way the problem was analyzed, (c) possible solutions that were generated, and (d) the way in which pros and cons of solutions were considered, and choices made, implemented, and evaluated.

3. Presentation of an interpersonal problem and group discussion of why the person involved wants to resolve the problem and of how to analyze it.

4. Presentation of an appropriate analysis of a problem and group discussion and categorization of options.

5. Presentation of a range of options and specific steps for solving a problem; group discussion of pros and cons for evaluating which one should be pursued.

6. Presentation of a chosen alternative for solving a problem; group discussion of how to evaluate its effectiveness and to choose another option if necessary.

7. Presentation of a new problem with the preceding steps repeated as needed.

It is proposed that at least four problems be pursued in this fashion. By the fourth, the individual is to be able to do each facet of the problem-solving sequence during a given session. If not, up to three additional problems will need to be presented.

Evaluative feedback will underscore progress and satisfaction associated with accomplishment of program objectives and solving interpersonal problems at school. Consequences that the individual experiences when such problems are not solved appropriately also need to be highlighted.

*During any step, as appropriate, the discussion may include role-playing, use of puppets with younger children, and so on. Initially, the intervener provides categories of ideas that may have been missed. All ideas generated during discussion are to be charted for subsequent reference.

Summing up

Obviously, the ideas discussed here represent only a beginning. Given the growing interest in the areas of systematic enhancement of motivation and the training of social skills, we anticipate that programs for individuals with learning and behavior problems will increasingly incorporate procedures that reflect strategies for simultaneously enhancing motivation and skills.

Intervention:

Behavior Management & Self-Instruction

A popular approach for working with youngsters with social and interpersonal problems in classrooms was published in LD Forum, Vol 21 (1), Fall, 1995, by Judith Osgood Smith from Purdue University Calumet.

GETTING TO THE BOTTOM OF SOCIAL SKILLS DEFICITS

When someone mentions **behavior management,** our first thought may be about controlling students or stopping them from performing inappropriate behaviors. We expend a great deal of energy managing students so that inappropriate behaviors will not occur. However, successful termination of inappropriate behavior is no guarantee that appropriate behavior will take its place. One of the most puzzling and frustrating problems encountered by parents and teachers of students with learning disabilities (LD) is not the student who obviously acts out or engages in overtly antisocial behaviors, but rather the one who simply fails to perform the appropriate behavior for a given circumstance or setting. This problem is frequently labeled a social skill deficit (Gresham & Elliott, 1989).

Students with LD may exhibit social skill deficits that are either skill-based or performance-based. In other words, either the skill may not be in the student's repertoire or the student may have acquired the skill but it is not performed at an acceptable level. Effective intervention requires identification and remediation of the specific type of deficit exhibited by the student. This article will delineate the differences between skill-based and performance-based social skills deficits and present intervention approaches in each area.

SKILL-BASED DEFICITS

A skill-based deficit exists when a student has not learned how to perform a given behavior. For example, a student who has not learned to do long division could be said to have a long division skill deficit. Similarly, a student who hasn't mastered the skill of greeting others appropriately may have a skill deficit in that area. Few parents or teachers would punish a student for not knowing how to do long division. Unfortunately, however, we sometimes become angry with students when they don't demonstrate the social skill we desire them to display. Reprimands and loss of privileges are common reactions. A critical issue is whether the student actually possesses the desired skill. If not, it is unreasonable to demand that it occur or scold the student if it doesn't. Our anger and punishment can only add to the frustration of the student who knows he or she did something wrong, but has no clue as to how to fix it.

We may determine if a student has a skill deficit by observing whether the desired skill has ever been performed. If not, one may hypothesize that the skill is not in the student's repertoire. This may be tested further by providing strong incentives to perform the desired behavior. If the student fails to perform under these conditions, it is likely that the problem stems from a skill deficiency. The bottom line: don't scold or reprimand the student for having a skill-based deficit; instead, teach the skill.

Teaching Social Skills

Generally, a skill-based deficit is due to lack of opportunity to learn or limited models of appropriate behavior (Gresham & Elliott, 1989). Even given the opportunity to learn and the appropriate model, students with LD may not learn these skills incidentally or intuitively. In these instances, direct instruction, or skill training, is necessary. The same principles apply to teaching social skills as to academic skills: provide ample demonstration/modeling, guided practice with feedback, and independent practice.

Hazel, Schumaker, Sherman, and Sheldon-Wildgen (1981) listed eight fundamental social skills which can be taught through direct instruction:

1. Giving positive feedback (e.g., thanking and giving compliments),
2. Giving negative feedback (e.g., giving criticism or correction),
3. Accepting negative feedback without hostility or inappropriate reactions,
4. Resisting peer pressure to participate in delinquent behavior,
5. Solving personal problems,
6. Negotiating mutually acceptable solutions to problems,
7. Following instructions, and
8. Initiating and maintaining a conversation.

They recommended teaching these skills by providing definitions, illustrations with examples, modeling, verbal rehearsal, behavioral rehearsal, and additional practice.

Similarly, Walker, Colvin, and Ramsey (1995) recommended a nine-step direct instructional procedure, the ACCEPTS instructional sequence. The steps include:

1. Definition of the skill with guided discussion of examples,
2. Modeling or video presentation of the skill being correctly applied,
3. Modeling or video presentation of incorrect application (non example),
4. Review,
5. Modeling or video presentation of a second example with debriefing,
6. Modeling a range of examples, coupled with hypothetical practice situations,
7. Modeling or video presentation of another positive example if needed,
8. Role playing, and
9. Informal commitment from student to try the skill in a natural setting.

In summary, students with LD who have not acquired social skills are not likely to learn casually or incidentally. Intervention for skill-based deficits should focus on direct instruction of the skill. Effective instructional methods include demonstration/modeling with guided practice and feedback.

PERFORMANCE-BASED DEFICITS

A performance-based deficit exists when the student possesses a skill but doesn't perform it under the desired circumstances. This may occur if there is a problem with either motivation or with ability to discriminate as to when to exhibit the appropriate behavior.

Motivational Deficit

When a motivational deficit exists, the student possesses the appropriate skill, but doesn't desire to perform it. A motivational deficit may be hypothesized if observations reveal that the student has acquired the desired skill, but motivational conditions are not sufficiently strong to elicit it. The hypothesis may be confirmed if the student performs the behavior following introduction of a motivational strategy. For example, in the area of conversation skills, we may suspect that a student is capable of interpreting cues from peers that indicate that it is someone else's turn to talk, but instead chooses to interrupt. This theory may be verified if the student waits to speak when rewarded for taking turns. The student could then be considered to have a motivational deficit. In situations such as this, behavioral interventions are effective.

Motivational Strategies. Parents and teachers of students with motivational deficits can manipulate contingencies that will encourage performance of prosocial behaviors by using the principles of Applied Behavior Analysis (ABA). The steps include defining the target behavior operationally, identifying antecedents and consequences related to the behavior, and finally developing and carrying out a plan to alter the antecedents and consequences so that the desired behavior will occur. For example, the behavior of "interrupting" may be defined as "speaking before your partner has completed his or her sentence." The antecedents to this behavior may be poor models and the consequence to interrupting may be attention from the listener. The next step is to develop a plan which encourages turn taking during conversations. An antecedent technique may be to remind the student about taking turns prior to a conversation and a consequence may be to pay attention only when the student waits his or her turn prior to speaking. Good school/home communication and collaboration can ensure consistency of carrying out the plan in both settings.

Most students of ABA who have succeeded at a self-improvement program such as a diet or exercise regime will confirm that the principles of ABA can be effectively used on oneself. Bos and Vaughn (1995) postulated that these same principles can be taught to adolescents so that they can implement a self-management program. The adolescent with LD would first learn to identify the behavior he or she wants to change, then identify the antecedents and consequences connected to the behavior, and, finally, develop an intervention which alters the antecedents and provides consequences that will maintain the desired behavior. A further suggestion would be to have the adolescent chart his or her progress toward a self-selected reward. To summarize, once identified, motivational deficits can be remediated using behavior management techniques, either by the adult in the situation, or by the student in question.

Discrimination Deficit

A student with a discrimination deficit has the desired skill in his or her repertoire, is motivated to behave properly, but can't discriminate, (i.e., doesn't know when to exhibit the desired behavior). A discrimination deficit may be confirmed if the student frequently performs the desired behavior, but fails to perform it under specific conditions. This may be due to an inability to glean relevant information from social situations. When a discrimination deficit exists, the student possesses the desired behavior but may not be sure as to when, where, and how much to engage in that behavior.

Bryan (1991) reviewed research on social competence of students with LD. Most studies found that students with LD had poorer social cognition than nondisabled or low-achieving students. A deficit in social cognition may be apparent in a student who is oblivious to social cues or who lacks understanding of the social demands of a situation (Bryan, 1994).

The Hidden Curriculum. Given the same information as everyone else, students with LD may not demonstrate appropriate social skills because they do not understand the hidden curriculum ascertained by more socially adept students. Lavoie (1994) suggested assessment of the student's knowledge of the hidden curriculum as a step in teaching the student to discriminate the appropriate behavior for a given situation. The first step is to determine the hidden curriculum, or culture, pertaining to the school the student attends. For example, what extracurricular activities are viewed by others as important? What are the hidden rules governing social functions? What is the administrative framework? Which teachers emphasize completion of daily assignments, punctuality, and/or class participation? This information can be obtained from teachers, support staff, and school publications such as the yearbook or school newsletter.

Once the hidden curriculum is identified, the next step is to assess the student's knowledge in key areas. There are many things which we may take for granted about which the student may be embarrassed or incapable of obtaining an explanation. Specifically, the following questions should be answered:

1. Does the student understand how the schedule works?
2. Does the student know how to get from one place to another in the school building?
3. Is the student aware of the requirements for

participation in extracurricular activities, including deadlines and eligibility procedures?
4. Can the student identify the social cliques?
5. Can the student identify support staff (e.g., the school nurse, the guidance counselor)? Does he or she know how to gain access to their services?

In short, the hidden curriculum must first be identified and then the student's level of understanding of it must be assessed. Only then can information be provided to the student to fill in the gaps.

Teaching Discrimination. A common characteristic of students with LD is impulsivity, the tendency to act without considering the consequences or appropriateness of one's behavior. This may be seen as an interfering behavior, which will be discussed in the following section. However, what on first glance appears to be impulsivity may in reality be an inability to understand the limits of acceptable behavior. Acceptability of behavior frequently varies according to the setting or circumstance. For example, a student may not know which teachers tolerate conversation and when it is appropriate to talk with peers. What is acceptable behavior on the playground may not be acceptable in the classroom.

According to Smith and Rivera (1993), "educators must help students learn to discriminate among the behavioral options in each school situation and match that situation with the proper behavior pattern" (p. 24). Some social skill problems occur simply because students do not understand how to read environmental cues that indicate whether or not a behavior is acceptable. In short, when there is a discrimination deficit, we must help the student size up the social situation and determine what to do. If the student cannot discriminate, we must teach what is acceptable in a given circumstance.

Lavoie (1994) introduced a problem-solving approach to teaching discrimination called the social autopsy. A social autopsy is the examination or inspection of a social error in order to determine why it occurred and how to prevent it from occurring in the future. When a student makes an academic error, we provide the right answer and use the mistake as an opportunity to learn. In other words, we teach the student how to "fix" the mistake. Similarly, Lavoie (1994) suggested that instead of punishing the student for making a social mistake, we should analyze it and use it as an opportunity to learn. The process involves asking the student, "What do you think you did wrong? What was your mistake?" By actively involving the student in discussion and analysis of the error, a lesson can be extracted from the situation which enables the student to see the cause-effect relationship between his or her behavior and the consequences or reactions of others.

Underlying the social autopsy are the following principles:

1. Teach all adults who have regular contact with the student to perform social autopsies. This includes family members, custodial staff, cafeteria workers, bus drivers, teachers, secretaries, and administrators. This will foster generalization by ensuring that the student participates in dozens of autopsies daily.
2. Conduct social autopsies immediately after the error occurs. This will provide a direct and instantaneous opportunity to demonstrate the cause and effect of social behaviors.
3. Use social autopsies to analyze socially correct behaviors as well as errors. This will provide reinforcement which may assist the student in repeating the appropriate behavior in another setting.
4. Help students identify and classify their own feelings or emotions.

There are several advantages of this method: (a) It uses the sound learning principles of immediate feedback, drill and practice, and positive reinforcement; (b) It is constructive and supportive rather than negative or punishing; (c) It provides an opportunity for the active involvement of the student, rather than an adult-controlled intervention; and (d) It generally involves one-on-one assistance to the student.

To summarize, limited awareness of the conventions of behavior and inability to decode the hidden curriculum and social cues contribute to deficits in discrimination of social skills. Interventions for students with these problems should be geared toward helping the student analyze the components of social situations so that discrimination can occur.

SELF-CONTROL

This article has discussed the classification and remediation of social skills deficits. However, there is one problem that may inhibit success, even if we are able to classify successfully the student's problem and design an appropriate intervention. Interfering or competing behaviors may interrupt the student's ability to learn or demonstrate appropriate social skills. Such problems can contribute to both skill and performance deficits so that a student may have difficulty either learning a new skill or performing it when appropriate.

Common interferences experienced by students with LD are impulsivity (the tendency to act without considering consequences or to choose the first solution that comes to mind), distractibility (tendency to focus on minor details, to pay attention to everything), and perseveration (repetition of behavior due to inability to change motoric or verbal responses; inability to shift gears). Hyperactivity (excessive motor activity) can also interfere. Either a systematic behavioral approach or self-management techniques may be helpful, depending on the student, the situation, and the interfering behavior. For the distractible student, self-monitoring and charting of attention or work completed may be helpful. Students who are impulsive can learn problem-solving strategies which force them to dissect problems and evaluate possible consequences. Bos and Vaughn (1994) recommended a strategy called FAST for this purpose.

The steps in FAST are:

1. Freeze and think! What is the problem?
2. Alternatives? What are my possible solutions?
3. Solution evaluation. Choose the best solution: safe? fair?
4. Try it! Slowly and carefully. Does it work (p.371)?

CONCLUSION

In conclusion, remediation must be directly related to the type of social skill deficit. If the student has a skill-based deficit, the appropriate intervention strategy is to teach the deficient skill. If motivation is a problem, behavioral interventions are appropriate. If the student has difficulty discriminating what is the acceptable behavior for a given circumstance, we must provide the information needed so that discrimination is possible and assist the student in analyzing positive social behaviors as well as social errors. Interfering behaviors must also be considered. Educators and parents can do much to alleviate social skills problems by discerning whether social skills deficits are skill-based or performance-based and designing interventions accordingly.

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Intervention:

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain excerpts from a 1995 report entitled "Prevention of Behavioral and Social Problems: The Need for Preventive Services by J. A. Durlak, from *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Excerpted here are the abstract, an adapted table categorizing relevant research, and the authors' conclusions.

Abstract from J. A. Durlak, from *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: Sage.

Although there is no standardized reporting system, information summarized by Knitzer, Steinberg, and Fleisch (1990) suggests that relatively few maladapting schoolchildren receive school-based mental health care and that those who do receive services that are neither lengthy nor timely. For instance, although up to 15% of schoolchildren experience clinical-level dysfunction, schools formally designate only 1% of the school population as having serious problems, labeling them behaviorally or emotionally disturbed. Only two-thirds to three-fourths of these children receive any school mental health services, and less than half receive more than five sessions a year. Finally, although most children with serious problems are identified in the early primary grades, the majority who receive any mental health treatment are between 12 and 16 years old. Programs to prevent behavioral and social maladjustment could fill an important need by helping many school-age children who will likely never receive any mental health care....

The following pages highlight the gist of the author's conclusions.

PRIMARY PREVENTION

Durlak, Lampman, Wells, and Cotten (1993) conducted a meta-analysis evaluating controlled outcome studies of primary prevention that had appeared through the end of 1991. The major findings for the 131 school-based programs in this review are presented in Table 2.1. Results for different types of programs are expressed in terms of mean effect sizes (ESs), which are standardized mean differences comparing the postintervention statuses of experimental and control groups. In brief, an ES reflects how much change has occurred from an intervention; higher numbers indicate stronger program impact. The appendix to this volume presents a brief explanation of ESs and their interpretation.

In general, all types of programs had significant positive impacts on participants; the mean ESs ranged from 0.25 to 0.50. It is helpful to compare these outcomes with those obtained from other types of treatments. Lipsey and Wilson (1993) report that the mean ES obtained from 156 different meta-analyses evaluating various social, behavioral, and educational treatments was 0.47 (SD = 0.28). The results obtained for primary prevention programs are within this range. Compared with treatments for dysfunctional children, slightly lower mean effects can be expected for primary prevention programs, because children in such programs are initially functioning within the normal range.

TABLE 2.1 Mean Effect Sizes for Primary Prevention Programs to Prevent Behavioral and Social Problems

Type of Program	*All Out-*	*Mean Effect*	*Problems*
Environmental programs (17)	0.35	0.56	0.26
Transition programs			
divorce (7)	0.36	0.33	0.38
school entry/change (9)	0.39	0.41	0.36
Person-centered programs			
affective education (46)	0.29	0.31	0.26
interpersonal problem solving (23)	0.39	0.44	0.06[a]
Other programs			
behavioral (26)	0.50	0.44	0.55
nonbehavioral (16)	0.25	0.24	0.25

SOURCE: Data are drawn from Durlak et al. (1993).

NOTE: [a], Only mean effect *not* significantly different from zero.

Table 2.1 also presents mean ESs expressed in terms of either assessed competencies or problems. Outcomes assessing problems would include symptom checklists, self-reports of anxiety, and observations of inappropriate behavior; those evaluating competence would focus on assertiveness, interpersonal problem-solving skills, increases in self-esteem or self-efficacy, and so on. With the exception of problem-solving interventions, programs produced similar and significant effects on both competencies and problems. In other words, primary prevention programs had the dual effect of improving participants' status on indicators of both adjustment and maladjustment.

Competency enhancement coupled with a reduction in problems has important preventive implications. For example, a program that ends with participants having greater self-confidence and better coping abilities would seem to place participants at lower risk for future problems than a program that only reduces pathology.

Although outcome data for primary prevention programs are generally positive, conclusions about program impact are offered cautiously for two main reasons. First, only a minority of programs collected follow-up data (26%), and follow-up periods were relatively short in many cases. The median follow-up period was only 8 weeks, and only eight studies collected follow-up data at 1 year or later. Therefore, the durability of program impact for many interventions is largely unknown. Second, in several cases there was a failure to formulate and test specific hypotheses. For example, researchers have not always articulated specific program objectives or presented theory-based rationales for why interventions should achieve certain outcomes. The presence of vague goals (e.g., "to prevent school maladjustment") coupled with the use of measures that assess general aspects of functioning (e.g., self-esteem or anxiety) makes it difficult to interpret an intervention's preventive impact. There are significant exceptions to the above, however, and some exemplary programs that offer the strongest evidence for preventive effects are described in the following sections. Different types of interventions are presented below using the conceptual distinctions discussed in Chapter 1.

Person-Centered Approaches

Mental health promotion. One strategy in primary prevention involves health promotion, and two groups of studies fit this mold: those involving affective education and those involving interpersonal problem-solving training.

Programs involving affective education represent a diverse set of interventions that share the common goal of emotional and social growth. The general intent of these programs is to improve children's adjustment by increasing their self-understanding and self-acceptance, and by helping them understand factors that influence their own and others' feelings and behaviors. The availability of commercial programs and the intuitive appeal of this approach for teachers have made affective education very popular in the schools. Lesson plans and units are available for early and middle elementary students that combine puppet play, music, stories, group discussions, and various exercises....

* * *

Transition or Milestone Programs

There are two types of school-based transition programs: those designed for children of divorcing parents and those designed for children who are changing schools. The potential negative effects of divorce on children are well known (Emery, 1988). Programs for children of divorce adapt a variety of clinical techniques to help children deal with the stress of divorce. Opportunities for discussion, ventilation of feelings, and social support are provided, usually in a group context (e.g., Alpert-Gillis, Pedro-Carroll, & Cowen, 1989).

Because at least one third of all children will eventually experience the divorce of their parents, and in growing recognition that divorce can have negative effects on children's peer relations, school achievement, and personality functioning, interventions for children of divorce are becoming increasingly popular in the schools. Emery (1988) and Grych and Fincham (1992) offer excellent overviews of the issues involved in implementing and evaluating such interventions.

Children who must change schools represent another opportunity for primary prevention interventions. Approximately 6 million students (ages 5-13) change schools each year, and it is believed that many of them experience some difficulty in adjusting (Jason et al., 1992). Jason et al. (1992) have summarized findings from their School Transition Project, an attempt to help high-risk multiethnic middle school children (Grades 4-6) who were entering new inner-city schools. In successive studies, children considered to be at academic risk on the basis of low standardized achievement scores received an orientation program conducted by a sixth-grade peer and in-school academic tutoring during the new school year from college undergraduates or home tutoring from trained parents. In Study 1, experimental children improved significantly in achievement scores compared with controls, and 50% more experimental than control children moved out of the academic at-risk category. In Study 2, tutored children in both conditions again demonstrated academic gains and parent tutoring produced more favorable results on measures of classroom social behavior than in-school tutoring. Finally, 1-year follow-up of the first cohort indicated that experimental children had maintained their academic gains.

Environmental Programs

Although programs attempting environmental changes are in the minority (n = 17), the results of several interventions have been particularly impressive. For example, attempts at changing a school's psychosocial environment to increase peer and teacher support for low-income, multi-ethnic students have been successful (Felner & Adan, 1988). Instead of frequently changing classes and teachers, program students were kept together for core academic subjects. These students were in homerooms in which assigned teachers were trained to function as counselors and to offer social support for school-related difficulties. Significant program effects were obtained for grades, school attendance, self-concept, and positive perceptions of the school environment. A 3-year follow-up indicated significantly higher grades and lower absenteeism for program students and a 48% lower school dropout rate.

Weinstein et al. (1991) also successfully changed the school environment through a multicomponent intervention that focused on eight school features, including curricular student ability groupings, evaluation procedures, teacher-student relationships, and parent involvement. At-risk, multiethnic high school students changed significantly in grades, disciplinary referrals, and school absences compared with controls, and at 1-year follow-up had a 50% lower school dropout rate.

Hawkins et al. (1991) sought to prevent aggression and other acting-out behaviors by changing both the classroom and home environments of subjects in a program that combined teacher and parent interventions. Parents of low-income multiethnic children entering first grade received training in behavioral management practices for use in the home. Teachers were trained in proactive classroom management (see Chapter 4) and in specific interactive teaching methods. The latter included changing several instructional procedures in the class so that teachers monitored and reinforced student progress on individually paced academic tasks. Children were also trained in interpersonal problem-solving skills by their teachers. Compared with controls, experimental boys were significantly less aggressive and experimental girls were significantly less self-destructive, according to teacher ratings. Only 6% of experimental boys, compared with 20% of control boys, were in the clinical range of dysfunction on aggressive behavior.

Finally, the Houston Program (Johnson, 1988), which targeted low-income Mexican American families, is an example of environmental change occurring during early childhood. In this case, the multicomponent intervention involved the creation of a new setting, a child development center offering services to the entire family. The program, which began when the child was 1 year old, involved biweekly home visits and weekend sessions conducted by a paraprofessional child educator. These visits focused on issues related to parent-child interactions and early child development. ...

* * *

TABLE 2.3 Major Findings for Secondary Prevention Programs

	Mean Effect Size		
Type of Treatment			
behavioral (n=46)	0.51		
cognitive-behavioral (n=31)	0.53		
nonbehavioral (n=53)	0.27		
Presenting Problem			
externalizing (n=10)	0.72		
internalizing (n=38)	0.49		
mixed symptomatology (n=36)	0.38		
poor academic achievement (n=24)	0.26		
poor peer relations (n=21)	0.30		
Result for Follow-Up Studies	*Postintervention*	*Follow-Up*	*Follow-Up Period*
Behavioral (n=12)	0.54	0.47	5
Cognitive-behavioral (n=12)	0.80	0.84	3
Nonbehavioral (n=11)	0.09	0.11	24

SOURCE: Data are drawn from Dutlak and Wells (1994).

NOTE: n = number of studies.

SECONDARY PREVENTION

Secondary prevention programs (or indicated preventive interventions) provide prompt intervention for problems that are detected early; they typically operate as follows. A particular population in one or more schools (e.g., all first graders, all those in junior high) is screened or evaluated in some way and criteria are used to target some for intervention, which follows quickly after the collection of more information confirming the nature of the children's difficulties. The intent of secondary prevention is to help children with subclinical problems so that they avoid developing full-blown disorders. It is believed that the earlier the intervention occurs, the greater the likelihood of success. In other words, it makes sense to intervene when problems are just beginning rather than to wait for them to intensify over time.

There are two main aspects to secondary prevention programs. The first involves the early identification of school problems; the second involves the treatment provided to target children....

...A few examples illustrate the diversity of procedures used in secondary prevention programs. The best-known secondary prevention program is the Primary Mental Health Project (PMHP) begun by Cowen and his colleagues in Rochester, New York, in 1957 (see Cowen, 1980). so called because of its focus on the primary (early elementary) school grades and not because it is a primary prevention program, the PMHP basically offers individual relationship-oriented (nonbehavioral) treatment to children who have externalizing or internalizing problems as well as learning difficulties. Trained homemakers have been the major therapeutic agents.

Other programs have used social and token reinforcement to modify children's acting-out and shy/withdrawn behaviors (Durlak, 1977; Kirschenbaum, DeVoge, Marsh, & Steffen, 1980). Cognitive-behavioral therapy techniques emphasizing self-monitoring and self-control have been used effectively to reduce aggressive behavior (Camp, Blom, Herbert, & Van Doorninck, 1977; Lochman, Burch, Curry, & Lampron, 1984) and depressive symptomatology (Kahn et al., 1990). La Greca and Santogrossi (1980) used social learning procedures to train social isolates in skills designed to increase their rates of peer acceptance. In a frequently cited study, Oden and Asher (1977) found it was possible to coach socially isolated children on how to improve their peer interactions. Most of the above interventions have been offered in group formats, have been relatively brief (12 or fewer sessions), and have successfully used a variety of change agents, such as teachers (Camp et al., 1977), school counselors (Durlak, 1977; Kahn et al., 1990), and graduate and undergraduate students (Kirschenbaum et al., 1980; La Greca & Santogrossi, 1980; Lochman et al., 1984; Oden & Asher, 1977).

Program Outcomes

Durlak and Wells (1994) conducted a meta-analytic review of the impact of secondary prevention by evaluating the results of 130 published and unpublished controlled outcome studies appearing by the end of 1991. All of these studies used person-centered approaches, and most (94%) were conducted in schools. As the findings did not vary when the few nonschool programs were removed, results for the complete review are discussed here. Programs focused strictly on academic remediation and those to prevent drug taking were not included, but such programs are discussed in Chapters 3 and 4.

The design of secondary prevention programs varied widely. For example, a relatively high percentage of studies randomly assigned participants to treatment and control conditions (71%), used multiple outcome measures (91%), and had low attrition (76%). In contrast, relatively few designs included attention placebo controls (28%), collected follow-up data (29%), or used normed outcome measures (2096). None of the above procedures was significantly related to program outcomes, but the data reported above indicate how methodological improvements can be made in future studies.

Table 2.3 summarizes the main findings from this meta-analysis. Results are presented first for the general type of treatment used, which was the most important factor affecting outcomes. Behavioral and cognitive-behavioral treatments were equally effective in producing moderately strong effects (mean ES of 0.51 and 0.53, respectively), which were almost twice as high as those emanating from nonbehavioral interventions (mean ES = 0.27).

The effectiveness in treating different types of presenting problems is also indicated in Table 2.3. Surprisingly, programs targeting externalizing problems achieved the highest effects (mean ES = 0.72). This category included aggression and other forms of acting-out problems. Loeber (1990) has indicated that the possibility of modifying acting-out behaviors decreases with age. Therefore, prompt intervention for dysfunction detected early might be responsible for the ability of secondary prevention to reduce acting-out behaviors.

The most common internalizing problems treated in secondary prevention programs have been anxiety and depression, which appear amenable to early intervention (mean ES = 0.49). Although the effects for children with academic problems and poor peer relations are more modest (ESs of 0.26 and 0.30, respectively), each of these dimensions is predictive of later adjustment, so that even modest changes on these indices can have some preventive impact.

The bottom of Table 2.3 summarizes follow-up data for secondary prevention programs. The results are encouraging, given that there is no lessening of program impact over time; however, only 29% of all programs collected follow-up information and the follow-up period was relatively short in most cases.

Finally, in a fashion similar to the findings for program impact over time; however, only 29% of all programs collected follow-up information and the follow-up period was relatively short in most cases.

Finally, in a fashion similar to the findings for primary prevention, ESs were analyzed separately for outcome measures assessing competencies and problems. Although behavioral treatment produced higher effects than nonbehavioral interventions, both treatments were similar in ability to modify problems or competencies (mean ESs = 0.46 and 0.44 for behavioral treatment and 0.20 and 0.24 for nonbehavioral treatment, respectively). Cognitive-behavioral treatment did enhance competencies (mean ES = 0.39), but obtained much higher effects in terms of reducing problems (mean ES = 0.84).

In summary, results from 130 controlled outcome studies provide strong support for a secondary prevention model emphasizing timely intervention for subclinical problems detected early. Secondary prevention is applicable across a wide range of school settings, is appropriate for several different forms of dysfunction, and can be delivered in individual or group formats by diverse change agents. Various clinical procedures can be easily adapted once children in need of treatment are identified. Outcomes vary according to the type of treatment and presenting problem. In general, the best results are obtained for cognitive-behavioral and behavioral treatments and interventions targeting externalizing problems.

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Agencies and Online Resources Related to Social and Interpersonal Problems

The Shyness Home Page

This is an index to resources for shyness and social phobia.
www.shyness.com

Collaborative for the Advancement of Social and Emotional Learning (CASEL)

CASEL is an international collaborative of educators, scientists, policy makers, foundations, and concerned citizens promoting social and emotional educational and development in schools. Its mission is to promote social and emotioal learning (SEL) as an integral part of educaiton in schools throughout the world. CASEL's purpose is to encourage and support the creatino of safe, caring learninhg environments that build social, cognitive, and emotional skills.

Contact: University of Illinois at Chicago 1007 W. Harrison St., Chicago, IL 60607-7137
Ph. (312)413-1008 / Fax: (312)355-0559

Brief List of Some Major Social Emotional Learning Programs

The Collaborative for the Advancement of Social and Emotional Learning (CASEL) has produced a list of programs operating in schools and communities around the country. Some of these are presented below. They have taken some of the program descriptions from Chapter 5 of *Getting Started: The National Mental Health Association (NMHA) Directory of Model Programs to Prevent Mental Disorders and Promote Mental Health* (NMHA can be contacted at 703/838-7534).

CASEL notes that it "is currently engaging in a process of working with experts in the field of social and emotional learning to determine standards and to identify social and emotional learning programs that meet these standards. The list will be broadened as additional programs are identified. CASEL does not endorse the effectiveness of these programs and there is no implication that programs not included here are less well developed or less effective."

The Child Development Project

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Developmental Studies Center, 2000 Embarcadero, Suite 305, Oakland, CA 94606-5300
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The Child Development Project (CDP) is an effort to take research knowledge and theory about how elementary-school-age children learn and develop—ethically, intellectually, emotionally, and socially--and translate it into a comprehensive, practical program for classroom, school and home use. The CDP program seeks to strengthen children's tendencies to be caring and responsible, their motivation to learn, and their higher-order cognitive development. The overall program is both intensive and comprehensive. It includes a Classroom Program which focuses broadly on curriculum content, pedagogy, and classroom climate; a Schoolwide Program which focuses on school polities, practices, and events; and a Family Involvement Program which concentrates on creating, expanding, and maintaining links between school and home. In the Child Development Project, children become integrated into a school community in which the members are mutually supportive, concerned about one another's welfare, and interested in contributing to the life of the community. Evaluation findings have shown that CDP children do see their classrooms as caring communities, and that the more they do, the more their social, ethical and intellectual development are enhanced.

Going For The Goal Program (GOAL) at The Life Skills Center

Steven J. Danish, Director; Alice Westerberg, Administrative Assistant
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The Life Skills Center is an independent entity connected to Virginia Commonwealth University. The Center has as its mission to develop, implement and evaluate life skill programs for children, adolescents, and adults. Life skills are those skills that enable us to succeed in the environments in which we live. Some of these environments are in the family, schools, the workplace, neighborhood, and community. The Going for the Goal Program (GOAL) is our largest program. It is designed to teach adolescents a sense of personal control and confidence about their future so that they can make better decisions and ultimately become better citizens. To be successful in life it is not enough to know what to avoid; one must also know how to succeed. Thus, the focus is on teaching "what to say yes to" as opposed to "just say no." GOAL is a ten session, ten hour program taught by high school students to middle school students, both during school and after school. The life skills taught in GOAL are how to: (1) identify positive life goals; (2) focus on the process (not the outcome) of attaining these goals; (3) use a general problem-solving model; (4) identify health-compromising behaviors that can impede goal attainment; (5) identify health-promoting behaviors that can facilitate goal attainment; (6) seek and create social support; and (7) transfer these skills from one life situation to another.

I Can Problem Solve (ICPS): An Interpersonal Cognitive Problem Solving Program

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This program promotes problem solving, interpersonal interaction, and decision making. It is designed for preschool and school age children between the ages of 2 and 12. The program provides training in interpersonal cognitive problem solving skills, and also provides some parent training. Interpersonal Cognitive Problem Solving (ICPS) is designed to teach children not *what* to think, but *how* to think in ways that will help them to successfully resolve interpersonal problems. ICPS received the 1982 National Mental Health Association Lela Rowland Prevention Award in recognition of outstanding programming for the prevention of mental-emotional disabilities. The program is designed for children in preschool as well as elementary school students, with different curricula for each age group. Three teacher manuals for different age groups (preschool, kindergarten & primary grades, and intermediate elementary grades) are available from Research Press, 2612 N. Mattis Avenue, Champaign, IL 61821, 1-800-519-2707. A program for parents can be found in *Raising a Thinking Child,* Holt, 1994; paperback, Pocket Books, 1996. In addition, *Raising a Thinking Child: A Workbook will* also be available from Henry Holt soon. On-site training is available if desired. A video demonstration video tape can be obtained from the Mental Health Association of Illinois.

The New Haven Schools Social Development Program

Ramona Gattison, New Haven Public Schools, 54 Meadow Street, New Haven, CT 06519
Phone: (203) 946-5837

The Social Development Project of the New Haven Public Schools was launched in the fall of 1989 to respond to pervasive behavioral problems in students. Six years later, the project has become an official department of the school system. Its programming spans all 13 grade levels in all 43 schools. Evaluation data show these Social Development programs are responsive to the needs of students, teachers, parents, and administrators. "The Social Development Department" was titled in a conscious effort to use words and symbols that denote growth and development. The department continues in its original form today emphasizing three major goals: 1. To develop, implement, and evaluate a K-12 social competence promotion curriculum designed to promote positive and healthy development, while reducing the incidence of problem behaviors; 2. To design diverse school and community activities Slat reinforce She curriculum, channel energy of both children and adults into pro-social, structured activities in tandem with other prevention efforts; and 3. To strengthen school-based planning teams that include parents, teachers, and administrators to promote collaborative ownership of prevention programs and to strengthen the trust, climate, and relationships in both the school and the community.

The PATHS Curriculum

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The PATHS (Providing Alternative Thinking Strategies) Curriculum is a program for educators and counselors designed to aid development of self-control emotional awareness, and interpersonal problem-solving skills. The PATHS Curriculum provides teachers and counselors with a systematic developmental procedure for enhancing social competence and understanding in children. Children learn first to "stop and think," to develop and use verbal thought. Second, they learn the words to help mediate understanding of self and others. Third, students integrate this understanding with cognitive and linguistic skills to solve problems. Fourth and very critically, the program encourages language skills for self-control. PATHS is designed to help children: 1. develop specific strategies that promote reflective responses and mature thinking skills; 2. become more self-motivated and enthusiastic about learning, 3. obtain information necessary for social winding and pro social behavior, 4. increase their ability to generate creative alternative solutions to problems; and 5. learn to anticipate and evaluate situations, behaviors, and consequences. There have been three controlled studies with randomized control groups: one with regular children, one with special education-classified children and one with deaf/hearing impaired children. In *all three* studies, the use of the PATHS Curriculum has significantly increased the children's ability to do the following as assessed by individual child interviews: (a) Understand social problems, (b) Increase the children's understanding and recognition of emotions, (c) Develop effective alternative solutions, (d) Decrease the percentage of aggressive/violent solutions.

Positive Adolescents Choices Training (PACT)

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The PACT program prevents aggression in children through the promotion of social adjustment, social skills/competence, and anger management. The program is designed for African American middle school students between the ages of 12 and 15. PACT provides training in social and communication skills. The PACT program is a culturally sensitive toning program developed specifically for African American youth to reduce their disproportionate risk for becoming victims or perpetrators of violence. The cognitive/behavioral group training approach equips youngsters with specific social skills to use in situations of interpersonal conflict. The rationale for a social skills training approach rests on the assumption that poor interpersonal Skills, such as the inability to negotiate differences in opinion, increases the likelihood that a youngster may be drawn into physical aggression.

Reach Out to Schools: Social Competency Program

Pamela Seigle, Program Director, The Stone Center, Wellesley College, 106 Central Street,
Wellesley, MA 02181-8268 Phone: (617) 283-2847

The Reach Out to Schools: Social Competency Program is a comprehensive, multi-year social competency training program for elementary school (grades K-5) children, their teachers, principals, and parents. The year-long curriculum contains 40 lessons in three competency areas: 1) creating a cooperative classroom environment, 2) solving interpersonal problems, and 3) building self-esteem and positive relationships. Lessons are conducted twice each week for 15 minutes in an "Open Circle" format. The Open Circle provides a structured format to facilitate teaching social competency skills and also provides a consistent context for discussion of other issues important to members of the class. The Reach Out to Schools Program is an innovative prevention model that recognizes the central role that relationships play in the academic and social success of children. The Program works to develop growth-enhancing relationships in classrooms and throughout the entire school communities. The Program has identified goals for all levels of participants, from teachers and students to school administrators and parents. The Program will: (a) strengthen the social competency and facilitation skills of teachers and enable them to effectively implement the Social Competency Program curriculum in their classroom, (b) provide students with a structured and consistent environment in which they can establish, explore, and enhance relationships with their peers and adults and thereby develop their communication, self-control, and interpersonal problem-solving skills, (c) familiarize parents of participating children with the language, approaches, and objectives of the SCP curriculum and enable parents to effectively apply its principles to improve their parenting skill, (d) strengthen the social competency skills of school administrators and enable them to support the implementation of the core components of the SCP Program and to model its basic principles in their relationships with students, faculty, staff, and parents.

Resolving Conflict Creatively Program

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10003   Phone: (212) 387-0225   Fax: (212) 387-0510

The Resolving Conflict Creatively Program (RCCP) is a pioneering school-based program in conflict resolution and intergroup relations that provides a model for preventing violence and creating caring, learning communities. RCCP shows young people that they have many choices besides passivity or aggression for dealing with conflict; gives them the skills to make those choices real in their own lives; increases their understanding and appreciation of their own and other cultures; and shows them that they can play a powerful role in creating a more peaceful world. The overall goals of the RCCP National Center are: (a) to prepare educators to provide high quality instruction and effective school programs in conflict resolution and intergroup relations in a variety of settings across the country and (b) to transform the culture of participating schools so that they model values and principles of creative, non-violent conflict resolution. The program's primary strategy for reaching young people is professional development of the adults in their lives--principals, teachers, and parents. Through RCCP, we work intensively with teachers, introducing them to concepts and skills of conflict resolution, and continue supporting them as they teach those concepts and skills in an ongoing way to their students. RCCP provides teachers with in-depth training, curricula, and staff development support; establishes student peer mediation programs; offers parent workshops; and conducts leadership training for school administrators.

The Responsive Classroom

Northeast Foundation for Children, 71 Montague City Road, Greenfield, MA 01301
Ph: (800) 360-NEFC   Fax: (413) 772-2097   E-mail: nefc@crocker.com
They offer a free semi-annual newsletter

The Responsive Classroom is an approach to learning that integrates the teaching of academic skills and the teaching of social skills as part of everyday school life. Implemented by many public schools over the last fifteen years, The Responsive Classroom has six components:

- **Classroom Organization** that provides active interest areas for students and space for an appropriate mix of whole class, group and individual instruction.
- **Morning Meeting** which gives children daily opportunity to practice greetings, conversation, sharing and problem solving, motivating them to meet the day's academic challenges.
- **Rules and Logical Consequences** that are generated, modeled and role-played with the children and that become the cornerstone of classroom life.
- **Choice Time** for all children each day in which they must take control of their learning in some meaningful way, both individually and cooperatively.
- **Guided Discovery** of learning materials, room areas, curriculum content, and ways of behaving which deliberately and carefully introduces children to each new experience. There is no assumption that children already know how to do something before they begin.
- **Assessment and Reporting** to parents that is an evolving process of mutual communication and understanding.

The Social Competence Promotion Program for Young Adolescents (SCPP-YA)

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The Social Competence Promotion Program for Young Adolescents (SCPP-YA) develops skills for self-control to help adolescents control their emotions and engage in pro social coping behavior. The program also builds self-esteem, improves interpersonal interaction among peers, and teaches self and stress management. Within the academic and classroom environment, SCPP-YA promotes comprehensive school health education for improving student attitudes and students' school adjustment. The goals are to prevent adolescent pregnancy, aggressive behavior, conduct disorders, and juvenile delinquency. The program targets middle school students between the ages of 10 and 12. SCPP-YA provides training in assertiveness, social skills, and communication. These acquired skills are then applied to drug, health, and sex education. Teacher education is also used to facilitate the intervention. This is a school-based program involving young adolescents, who are given intensive instruction in social problem-solving skills while addressing other important issues like human growth and development, AIDS, adolescent pregnancy, sexual activity, and substance abuse. The core of this program includes a 27-lesson module wherein classroom teachers provide intensive instruction in social problem-solving skills.

The Social Decision Making and Life Skills Development Program: A Framework for Promoting Students' Social Competence and Life Skills and Preventing Violence, Substance Abuse and Related Problem Behaviors

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The Social Decision Making and Problem Solving (SDM-PS) program promotes decision making and conflict resolution skills in an academic environment to improve social competence. The goal is to prevent academic future, school dropout, violent social behavior, adolescent pregnancy, alcohol and other drug usage, and juvenile delinquency. This intervention targets elementary and middle school children between the ages of 6 and 14. SDM-PS provides training in problem solving, decision making, conflict resolution, group building, character development, communication, social skills and parenting through school-based academic, social, and health education. Social Decision Making and Problem Solving (SDM-PS) teaches children to think clearly under stress -- a skill considered to be common denominator in the effective promotion of academic and personal success and in the prevention of such serious problems as substance abuse, delinquency, and violence. Social Decision Making represents a family of curricular approaches with a common set of objectives:

- to calm down and re-organize themselves when they are under stress such as negative peer pressure
- to develop their understanding of social situations and their feelings and perspective of people to elaborate and clarify personally meaningful and pxosocial goals
- to consider possible alternative actions and their consequences
- to plan detailed strategies for reaching their goals
- to understand and accept soaat decisions for which there are no alternative, such as those related to drug use, illegal alcohol use, smoking, and the use of violence to resolve interpersonal disputes and conflicts.

IV. Increasing School Capacity to Prevent and Ameliorate Problems

For schools to be successful in addressing barriers to learning and teaching, they must build the capacity of the staff, expand the roles and functions of education support staff, enhance the involvement of those in the home, and a caring school culture. This section highlights these four key topics.

A. Capacity Building for Teachers and School Staff

B. Expanding the Role of Support Staff

C. Enhancing Home involvement and Forming Partnerships with Parents

D. Fostering a Caring School Culture

A. Capacity Building for Teachers and School Staff

Staff Consultation

Essentially, consultation is a collaborative problem solving intervention. Consultants enter into such a collaboration with the intent of improving the nature of intervention activity which others implement (Caplan, 1970; Cole & Siegel, 1990; Conoley & Conoley, 1990; Cummings, 1996; Friend & Cook, 1996; Gutkin & Curtis, 1982; Meyers, Parsons, & Martin, 1979; Rosenfield & Gravois, 1996; Sarason, 1996; Zins, Curtis, Graden, & Ponti, 1988; Zins, Kratochwill, & Elliott, 1994).

Mental Health Consultation in Schools

Mental health consultation focuses on the psychosocial aspects of human behavior and intervention processes and outcomes. In schools, mental health consultation is a critical facet of any comprehensive program to assist staff in addressing student's problems. This need stems from the fact that psychosocial factors must be well understood and accounted for in solving students' learning and behavior problems and reducing dropouts. This is the case in designing direct interventions and when referral for special services is necessary (assuming relevant services are available).

Although a considerable amount of school mental health consultation is focused on individual student problems, this need not and probably should not be the case. Such collaborative, problem solving consultation can be used to help improve classroom, school, or district-wide programs with respect to both overcoming problems and enhancing positive psychosocial development.

Collaborative Consultation

Truly collaborative problem solving requires considerable skill (see exhibit on next page). Even when consultation is sought and those seeking the consultation are highly motivated to problem solve, consultants must be adept at

- initiating and maintaining a working relationship

and

- facilitating collaborative problem solving.

Moreover, consultants must be committed and able to avoid undermining collaboration by sharing their expertise in ways that are consistent with empowering (e.g., equipping) those seeking consultation to solve future problems on their own.

With respect to collaborative consultation, Zins and his colleagues (1988) state that it involves

> a nonhierarchical, egalitarian relationship in that both the consultant and the consultee engage in efforts to develop effective intervention techniques. In other words, [they] are considered equal contributors to the problem-solving process as each brings different perspectives and areas of expertise to the situation.
>
> Although consultants should not unilaterally solve the problem and tell consultees which strategies to implement, both participants share responsibility for applying their expertise. Neither party should hold back ideas or interact predominantly in a nondirective manner. The purpose of collaboration is to establish an atmosphere that encourages all participants to contribute and share their expertise and resources (Tyler, Pargament, and Gatz, 1983; Zins, 1985) as collaboration can improve the flow of communication (Gutkin and Curtis, 1982) and facilitate creative problem solving (Sandoval, Lambert, and Davis, 1977). In fact, teachers have been found to prefer collaborative consultation to an expert approach; they perceive the collaborative consultant as being more attentive and the process as resulting in the development of more successful and relevant interventions (Wenger, 1979) (pp.29-30).

Recognizing the importance of consultant commitment to empowerment of those seeking consultation, Pugach and Johnson (1989) state that empowerment is

> a tricky issue relative to collaborative consultation.... For collaborative working relationships to be realized, specialists will have to work hard to shed the "expert" image to which they have been socialized and which many classroom teachers have come to expect of them. . . . Currently, a realistic balance has not been achieved .... What remains to be seen is whether we can challenge ourselves to advance to the next level, that is, recognizing collaboration can occur only when all participants have a common understanding of their strengths and weaknesses and demonstrate a willingness to learn from each other (p. 235).

On consulting in the schools

We do not know to what extent we can be of help ....

We do not present ourselves as experts who have answers...

We have much to learn about this helping process ...

Together we may be able to be of help to children ....

Sarason, Levine, Goldenberg, Cherlin, & Bennett (1960)

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B. Expanding the Role of Support Staff

The Role of Support Services

Pupil service professionals are confronted with a rapidly changing work situation. It seems clear that jobs will be reshaped as initiatives to restructure education and community services play out during the next decade. A widespread concern is that positions will be cut.

Rather than respond reactively, school support staff must proactively continue to assume major, varied, and expanding roles related to mental health in schools. As public schools struggle to address poor achievement and escalating psychosocial problems, many specific needs and opportunities related to addressing barriers to learning and enhancing healthy development warrant greater attention. There are fundamental concerns that must be handled regarding the understanding and classification of problems, what approaches are appropriate for different groups and individuals, how to plan and implement the most cost-effective intervention, and how to improve interventions and evaluate cost-effectiveness. These are areas to which school support staff have contributed already and can continue to do so. To clarify the point, a few examples should suffice.

Improving Efficacy and Cost Effectiveness

Emerging trends are reshaping the work of support services. With respect to intervention, support services must become a major force in expanding prevailing models and shaping current policy reforms. Efforts are particularly needed that focus on improving intervention efficacy and cost effectiveness through integrating physical and mental health and social services and restructuring that component of school programs designed to address psychosocial problems. For this to occur, however, attention must be devoted to conceptualizing, developing, implementing, and evaluating comprehensive, integrated models of intervention.

One place to begin is with analyses of the curricula used to train support service personnel. Ultimately, the field must develop a cadre of leaders who have a broader perspective than currently prevails if the next generation is to make significant breakthroughs in understanding and ameliorating students' problems and in facilitating psychosocial development.

New directions call for going beyond direct service and beyond traditional consultation. Support services must be prepared not only to provide direct help but to assume key roles as advocates, catalysts, brokers, and facilitators of systemic reform and in resolving planning, implementation, and evaluation problems that arise related to school psychosocial and mental health programs. A pressing need is for research that clarifies what is involved in increasing the fidelity with which empirically supported interventions are translated into large-scale programs. In the process, such work will provide data upon which programs and systemic change strategies work and which do not in school settings. In this respect, a special focus is needed on expanding the concept of systems of care to all students who are involved in multiple programs of assistance and adding concepts such as systems of prevention and systems of early intervention and evolving ways such systems can operate in a seamless manner. By developing and demonstrating the efficacy of processes resulting in well-planned and implemented programs that weave together a continuum of interventions for youngsters, it should finally be possible to conduct evaluative research that fairly tests the cost-effectiveness of comprehensive, integrated approaches. Such research also should yield fundamental knowledge about human behavior and the nature of interventions that influence such behavior.

Needed: A Radical Change in the Systems that Educate School Support Staff

Clearly, this discussion stresses the need for major modification of preservice and continuing education for school professionals. Efforts to change the prevailing curriculum, of course, are continuing, and this is not the place for another discussion of the deficiencies in preservice and inservice education.

Instead, we offer an initial draft of a working curriculum content outline developed by the Center for Mental Health in Schools at UCLA. The outline is intended as an aid in rethinking the content of what school support staff need to know to play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what schools can do with what the community offers. As a next step in operationalizing a curriculum, the Center staff has generated continuing education modules based on this outline and has begun widespread dissemination through the Internet, as well as in hard copy format. The Center invites feedback to guide continuing efforts to evolve this work.

As the outline below suggests, changing roles for school support staff means a much expanded curriculum. It has always been clear that preservice education can provide only a modicum of what a professional must know and be able to do. Despite this awareness, the curriculum for professionals rarely is conceived as a coordinated whole: preservice presents the minimal standards required for practice; the first years of inservice focus in a cohesive way on the uncovered content; and continuing education addresses the problems of specialization and continuing changes in the field. Although the modules developed by our Center are aimed at offering the content as continuing education to help meet the needs of practicing school support staff the intent also is to influence the redesign of preservice curricula and encourage a rethinking of inservice programs.

I. Mental Health in School: An Introductory Overview

II. The Need

- A. Barriers to Learning (including physical and mental health problems)
- B. Promoting Healthy Development (physical and mental including fostering resiliency)
- C. Personal and Systemic Barriers to Learning
  - Psychosocial problems
  - Psychopathology
  - Environmental stressors
  - Student and environment mismatch
- D. Family Needs for Social/Emotional Support
- E. Staff Needs for Social/Emotional Support
- F. Limitations as Challenges

III. Addressing the Needs

- A. Understanding What Causes Different Types of Problems
- B. Legislative Mandates
- C. Clinical Approaches in School Sites
- D. Programmatic Approaches: Going Beyond Clinical Interventions
  - Working with classroom teachers
  - Systems for student and family assistance
  - Crises/emergencies: response prevention
  - Supporting student and family transitions
  - Mobilizing parent/home involvement in schooling and health promotion
- E. Toward a Comprehensive, Integrated Continuum of Interventions
  - Primary prevention of problems (including a major emphasis on promoting opportunities, wellness, and positive physical and mental development)
  - Early-age interventions for problems (including prereferral interventions)
  - Early-after-problem onset interventions (including prereferral interventions)
  - After the problem has become chronic

IV. Roles for School Support Staff: A Multifaceted Focus

- A. Problem Identification, Referral, Triage, and Assistance (including helping to develop referral and triage systems)
  - Assessment
  - Psychological first aid
  - Open-enrollment programs
  - Information-giving and didactic approaches
  - Counseling
  - Support and maintenance of students receiving psychotropic medication
- B. Developing Systems for Case, Resource, and Program Coordination, Monitoring, and Management
- C. Collaborative Teams
- D. Community Outreach
- E. Training Aides, Volunteers, and Peers to Help with Targeted Individuals and Groups
- F. Providing Inservice Staff Training
- G. Working for Systemic Changes and Getting the Right Support from the School District

V. Working Relationships and Cultural, Professional, and Individual Differences

- A. Matching Motivation and Capabilities
  - Building on strengths and resiliency
  - Minimizing weaknesses, resistance, and reactance
  - Least intervention needed
- B. Support, Guidance, Accommodations, and Appropriate Limit Setting

A Team to Manage Care

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide. Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress. Such ongoing monitoring requires systems for

- tracking client involvement in interventions
- amassing and analyzing data on intervention planning and implementation
- amassing and analyzing progress data
- recommending changes

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information (see Module II). In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary. Sometimes steps must be taken to Improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's care givers at home.

Who does all this monitoring and management of care? Ideally, all involved parties, interveners and clients assume these functions and become the management team. One member of such a team needs to take primary responsibility for management of care (primary manager). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is to train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

All who become primary managers of care must approach the role in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care. Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner designed to address the whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams should meet whenever analysis of monitoring information suggests a need for program changes and at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure that care is appropriately monitored, team meetings are called as changes are needed, and that changes are implemented. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure the changes are made.

The following list itemizes a few basic tasks for primary managers of care:

- Before a team meeting, write up analyses of monitoring data and any recommendations to share with management team.
- Immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks and when.
- Set-up a "tickler" system to remind you when to check on whether tasks have been accomplished.
- Follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

A Team to Manage Resources

School practitioners are realizing that since they can't work any harder, they must work smarter. For some, this translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts start with new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement.

An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-efficacy) is seen in the concept of a resource coordinating team. Creation of such a school-based team provides a vehicle for building working relationships and a good mechanism for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

Where such a team is created, it can be instrumental in integrating the center into the school's ongoing life. The team solves turf and operational problems, develops plans to ensure availability of a coordinated set of services, and generally improves the school's focus on mental health.

A resource coordinating team differs from teams created to review individual students (such as a student study team, a teacher assistance team, a case management team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing systems to coordinate, integrate, and strengthen interventions. For example, this type of mechanism can be used to weave together the eight components of school health programs to better address such problems as on-campus violence, substance abuse, depression, and eating disorders. Such a team can be assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring there are effective systems for referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and information and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Although a resource-oriented team might focus solely on psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual and Title I program coordinators). This includes representatives of any community agency that is significantly involved at the school. It also includes the energies and expertise of one of the site's administrators, regular classroom teachers, non-certificated staff, parents, and older students. Where creation of "another team" is seen as a burden, existing teams can be asked to broaden their scope. Teams that already have a core of relevant expertise, such as student study teams, teacher assistance teams, and school crisis teams, can extend their functions to encompass a focus on resources. To do so, however, they must take great care to structure their agenda so sufficient time is devoted to the added tasks.

Properly constituted, trained, and supported, a resource coordinating team can complement the work of the site's governance body through providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource coordinating team on the school's governing and planning bodies helps ensure that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction.

Mapping Resources

The literature on resource coordination makes it clear that a first step in countering fragmentation involves "mapping" resources by identifying what exists at a site (e.g., enumerating programs and services that are in place to support students, families, and staff; outlining referral and case management procedures. A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff.

Based on analyses of what is available, effective, and needed, strategies can be formulated for resource enhancement. These focus on (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) better ways to use existing resources. (The process of outreach to community agencies is made easier where there is policy and organization supporting school-community collaboration. However, actual establishment of formal connections remains complex and is becoming more difficult as publicly-funded community resources dwindle.)

Perhaps the most valuable aspect of mapping and analyzing resources is that the products provide a sound basis for improving cost-effectiveness. In schools and community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination. These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to come by, such redeployment of resources is the primary answer to the ubiquitous question: Where will we find the funds?

Available from the Center for Mental Health in Schools for a set of surveys designed to guide mapping of existing school-based and linked psychosocial and mental health programs and services.

Local Schools Working Together

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), a resource coordinating council can be established by bringing together representatives of each school's resource coordinating teams. Such a complex of schools needs to work together because in many cases they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a complex of schools provides a mechanism to help ensure cohesive and equitable deployment of such resources.

Fully Integrated with School and Community Resources

Most schools and many community services use weak models in addressing barriers to learning. The primary emphasis in too many instances is to refer individuals to specific professionals, and this usually results in narrow and piecemeal approaches to complex problems, many of which find their roots in a student's environment. Over-reliance on referrals to professionals also inevitably overwhelms limited public-funded resources.

More ideal models emphasize the need for a comprehensive continuum of community and school interventions to ameliorate complex problems. Such a continuum ranges from programs for primary prevention and early-age intervention -- through those to treat problems soon after onset -- to treatments for severe and chronic problems. Thus, they emphasize that promoting healthy development and positive functioning are one of the best ways to prevent many problems, and they also address specific problems experienced by youth and their families.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives designed to restructure community health and human services and the way schools operate.

To be most effective, such interventions are developmentally-oriented (i.e. beginning before birth and progressing through each level of schooling and beyond) and offer a range of activity -- some focused on individuals and some on environmental systems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical/mental health, preschool and early school adjustment programs, programs to improve and augment social and academic supports, programs to intervene prior to referral for intensive treatments, and intensive treatment programs. It should be evident that such a continuum requires meshing together school and community resources and, given the scope of activity effectiveness and efficiency require formal and long-lasting interprogram collaboration.

One implication of all this is formulated as the proposition that a comprehensive, integrated component to address barriers to learning and enhance healthy development is essential in helping the many who are not benefitting satisfactorily from formal education. Schools and communities are beginning to sense the need to adopt such a perspective. As they do, we will become more effective in our efforts to enable schools to teach, students to learn, families to function constructively, and communities to serve and protect. Such efforts will no longer be treated as supplementary ("add-ons") that are carried out as fragmented and categorical of services; indeed, they will be seen as a primary, essential and integrated component of school reform and restructuring.

Some General Guidelines Related to Establishing School-Site Collaborative Teams Focused on Addressing Barriers to Learning

A basic problem in forming teams is that of identifying and deploying committed and able personnel and establishing an organizational structure that nurtures the competence and commitment of team members. Based on experiences, the following general considerations related to school-based teams also are worth highlighting here.

1. Teams for programmatic areas may consist of current resource staff, special project staff, teachers, site administrators, parents, older students, and others from the community. In this last regard, representatives of school-linked community services must be included.

2. For staff, job descriptions must be written in ways that call on personnel to work in a coordinated and increasingly integrated way with the intent of maximizing resource use and enhancing efficacy.

3. To maximize the range of programs and services at a school, every staff member must be encouraged to participate on some team designed to enhance students' classroom functioning. The importance of such teams should be recognized through provision of time and resources that allow team members to work effectively together.

4. Each group can vary in size--from two to as many as are needed and interested. Major criteria used in determining size should be factors associated with efficient and effective functioning. The larger the group, the harder it is to find a meeting time and the longer each meeting tends to run. Frequency of meetings depends on the group's functions, time availability, and ambitions. Properly designed and trained teams can accomplish a great deal through informal communication and short meetings.

5. The core of a team is staff who have or will acquire the ability to carry out identified functions and make the mechanism work; others can be auxiliary members. All should be committed to the team's program-focused agenda. Building team commitment and competence should be one major focus of school management policies and programs.

6. Because several areas of program focus require the expertise of the same staff (nurse, psychologist, counselor, resource teacher, social worker), these individuals will necessarily be on several teams.

7. Each team needs a dedicated leader/facilitator who has the ability to keep the group task-focused and productive and someone who records decisions and plans and reminds members of planned activity and products.

8. Team functioning is enhanced through use of computer technology (management systems, electronic bulletin boards and mail, resource clearinghouses). Such technology facilitates communication, networking, program planning and implementation, linking activity, and a variety of budgeting, scheduling, and other management concerns.

9. Effective teams should be able to produce savings in terms of time and resources through appropriately addressing the programmatic areas in which they are involved. In addition, by tapping into public health-care funds, a district may be able to underwrite some of the costs of those team members who also provide specific services.

Prepared by the School Mental Health Project/Center for Mental Health in Schools, UCLA. March 1996.

C. Enhancing Home Involvement and Forming Partnerships with Parents

Currently, all school districts are committed to some form of parent involvement. However, we have learned the hard way that the term means different things in different schools and among the various stakeholders at any school. There are two lessons that seem fundamental.

First, we find that most efforts to involve parents seem aimed at those who want and are able to show up at school. It's important to have activities for such parents. It's also important to remember that they represent the smallest percentage of parents at most schools. What about the rest? Especially those whose children are doing poorly at school. Ironically, efforts to involve families whose youngsters are doing poorly often result in parents who are even less motivated to become involved. Typically, a parent of such a youngster is called to school because of the child's problems and leaves with a sense of frustration, anger, and guilt. Not surprisingly, such a parent subsequently tries to avoid the school as much as feasible. If schools really want to involve such families, they must minimize "finger wagging" and move to offer something more than parent education classes.

A second basic lesson learned is that in many homes mothers or fathers are not the key to whether a youngster does well at school. Many youngsters do not even live with their parents. Besides those placed in foster care, it is common for children to live with grandparents, aunts, or older siblings. Moreover, even when a youngster is living with one or more parents, an older sibling may have the greatest influence over how seriously the individual takes school. Given these realities, we use the term home involvement and try to design involvement programs for whoever is the key influence in the home.

Home involvement is a basic area for enabling learning. Schools must develop programs to address the many barriers associated with the home and the many barriers in the way of home involvement. Unfortunately, as with other facets of enabling learning, limited finances often mean verbal commitments are not backed up with adequate resources. Meaningful home involvement requires on-site decision makers to commit fully. This means creating and maintaining effective mechanisms for program development and overcoming barriers related to home involvement.

There are many ways to think about an appropriate range of activities. We find it useful to differentiate whether the focus is on improving the functioning of individuals (students, parent care taker), systems (classroom, school, district), or both. And with respect to those individuals with the greatest impact on the youngster, we distinguish between efforts designed mainly to support the school's instructional mission and those intended primarily to provide family assistance (see below).

Improve
Individual

- *meeting-basic obligations to the functioning student/helping caretakers meet their own basic needs
- *communicating about matters essential to the student
- *making essential decisions about the student
- *supporting the student's basic learning and development at home
- *solving problems and providing support at home and at school re: the students special needs
- *working for a classroom's/school's improvement
- *working for improvement of all schools

Improve
system
functioning

A Few Resources

From Parent Involvement to Parent Empowerment and Family Support -- A resource guide for school community leaders: Using the nationally-acclaimed RAINMAKER program, this resource calls for restructuring how educators and families work together, defines roles for each, highlights parent-run Family Resource Centers, provides a step-by-step model of training for parents, covers matters related to funding, and much more. By Briar-Lawson, Lawson, Rooney, Hansen, White, Radina, & Herzog. Available from the Institute for Educational Renewal. Ph: 513/529-6926.

Available from our Center:

Introductory packet: *Parent & Home Involvement in Schools*. Provides an overview of how home involvement is conceptualized and highlights models and resources. Issues of special interest to underserved families are addressed

Technical aid packet on: *Guiding Parents in Helping Children Learn*. Contains (1) a "booklet" to help nonprofessionals understand what is involved in helping children learn, (2) info about basic resources for learning more about helping parents and other nonprofessionals enhance children's learning, and (3) info on other resources parents can use.

D. Fostering a Caring School Culture

Schools often fail to create a caring culture. A caring school culture refers not only to caring for but also caring about others. It refers not only to students and parents but to staff. Those who want to create a caring culture can draw on a variety of ideas and practices developed over the years.

Who is Caring for the Teaching Staff?

Teachers must feel good about themselves if classrooms are to be caring environments. Teaching is one of society's most psychologically demanding jobs, yet few schools have programs designed specifically to counter job stress and enhance staff feelings of well-being.

In discussing "burn-out," many writers have emphasized that, too often, teaching is carried out under highly stressful working conditions and without much of a collegial and social support structure. Recommendations usually factor down to strategies that reduce environmental stressors, increase personal capabilities, and enhance job and social supports. (See our introductory packet: *Understanding and Minimizing Staff Burnout*)

What tends to be ignored is that schools have no formal mechanisms to care for staff. As schools move toward local control, they have a real opportunity to establish formal mechanisms and programs that foster mutual caring. In doing so, special attention must be paid to transitioning in new staff and transforming working conditions to create appropriate staff teams whose members can support and nurture each other in the classroom every day. Relatedly classrooms should play a greater role in fostering student social-emotional development by ensuring such a focus is built into the curricula.

Helping Youngsters Overcome Difficulty Making Friends

A caring school culture pays special attention to those who have difficulty making friends. Some students need just a bit of support to overcome the problem (e.g., a few suggestions, a couple of special opportunities). Some, however, need more help. They may be very shy, lacking in social skills or may even act in negative ways that lead to their rejection. Whatever the reason, it is clear they need help if they and the school are to reap the benefits produced when individuals feel positively connected to each other.

School staff (e.g., teacher, classroom or yard aide, counselor, support/resource staff) and parents can help such students. The following is one set of strategies that can be helpful:

- Identify a potential "peer buddy" (e.g., a student with similar interests and temperament or one who will understand and be willing to reach out to the one who needs a friend)
- Either directly enlist and train the "peer buddy" or design a strategy to ensure the two are introduced to each other in a positive way
- Create regular opportunities for shared activities/projects at and away from school (e.g., they might work together on cooperative tasks, be teammates for games, share special roles such as being classroom monitors, have a sleep-over weekend)
- Facilitate their time together to assure they experience good feelings about being together.

It may be necessary to try a few different activities before finding some they enjoy doing together. For some, the first attempts to match them with a friend will not work out. (It will be evident after about a week or so.) If the youngster really doesn't know how to act like a friend, it is necessary to teach some guidelines and social skills. In the long-run, for almost everyone, making friends is possible and is essential to feeling cared about.

A useful resource in thinking about strategies for helping youngsters find, make, and keep friends is: *Good Friends are Hard to Find* a 1996 book written for parents by Fred Frankl (published by Perspective Publishing); the work also has sections on dealing with teasing, bullying, and meanness and helping with stormy relationships.

Applying Rules in a Fair and Caring Way

Should different consequences be applied for the same offense when the children involved differ in terms of their problems, age, competence, and so forth?

Teachers and parents (and almost everyone else) are confronted with the problem of whether to apply rules and treat transgressions differentially. Some try to simplify matters by not making distinctions and treating everyone alike. For example, it was said of Coach Vince Lombardi that he treated all his players the same -- like dogs! A caring school cannot treat everyone the same.

Teachers and other school staff often argue that it is unfair to other students if the same rule is not applied in the same way to everyone. Thus, they insist on enforcing rules without regard to a particular student's social and emotional problems. Although such a "no exceptions" strategy represents a simple solution, it ignores the fact that such a nonpersonalized approach may make a child's problem worse and thus be unjust.

A caring school culture must develop and apply rules and offer specialized assistance m ways that recognize that the matter of fairness involves such complicated questions as, Fair for whom? Fair according to whom? Fair using what criteria and what procedures for applying the criteria? Obviously what is fair for the society may not be fair for an individual; what is fair for one person may cause an inequity for another. To differentially punish two students for the same transgression will certainly be seen as unfair by at least one of the parties. To provide special services for one group's problems raises the taxes of all citizens. To deny such services is unfair and harmful to those who need the help.

Making fair decisions about how rules are applied and who should get what services and resources involves principles of *distributive justice*. For example, should each person be (1) responded to in the same way? given an equal share of available resources? (2) responded to and provided for according to individual need? (3) responded to and served according to his or her societal contributions? or (4) responded to and given services on the basis of having earned or merited them? As Beauchamp and Childress (1989) point out, the first principle emphasizes equal access to the goods in life that every rational person desires; the second emphasizes need; the third emphasizes contribution and merit; and the fourth emphasizes a mixed use of such criteria so that public and private utility are maximized (in *Principles of Biomedical Ethics*). Obviously, each of these principles can conflict with each other. Moreover, any may be weighted more heavily than another, depending on the social philosophy of the decision maker.

Many parents and some teachers lean toward an emphasis on individual need: That is, they tend to believe fairness means that those with problems should be responded to on a case-by-case basis and given special assistance. Decisions based on individual need often call for exceptions to how rules are applied and unequal allocation and affirmative action with regard to who gets certain resources. When this occurs, stated intentions to be just and fair often lead to decisions that are quite controversial. Because building a caring school culture requires an emphasis on individual need, the process is not without its controversies.

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It is easy to lose sight of caring, and it is not easy to develop and maintain a caring school culture. In an era when so many people are concerned about discipline, personal responsibility, school-wide values, and character education, caring counts. Indeed, it may be the key to student well-being and successful schools.

Research on Youth and Caring

Protective factors. In the May 1995 issue of *Phi Delta Kappan*, a series of articles discuss "Youth and Caring." Included is an overview of findings from the research Project on Youth and caring (carried out through the Chapin Hall center for Children at the University of Chicago). Among a host of findings, researchers in that program report that caring and connectedness can protect against specific risk factors or stressful life events. The protective facets of caring are seen as transcending differences in class, ethnicity, geography, and other life history variables.

What makes for a caring environment? Karen Pittman and Michelle Cahill studied youth programs and concluded that youngsters experience an environment as caring when it:

- creates an atmosphere where they feel welcome, respected, and comfortable,
- structures opportunities for developing caring relationships with peers and adults
- provides information, counseling, and expectations that enable them to determine what it means to care for themselves and to care for a definable group,
- provides opportunities, training, and expectations that encourage them to contribute to the greater good through service, advocacy, and active problem solving with respect to important matters.

V. General Resources and References

Some specific resources have been provided in the previous sections. This section offers general resources relevant to addressing barriers to student learning and mental health in schools.

Included is information on the following:

A. AGENCIES, ORGANIZATIONS AND INTERNET SITES THAT CAN PROVIDE MORE INFORMATION AND SUPPORT

B. GENERAL REFERENCES

C. A LIST OF SPECIAL RESOURCES AVAILABLE FROM THE UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS

A. Agencies, Organizations and Internet Sites That Can Provide More Information and Support

Our center has attempted to catalogue and categorize agencies, organizations, and internet sites relevant to addressing barriers to learning and mental health in schools. These catalogues are available from the center and most of the material is on our website.

In the section, we have excerpted some examples under the following headings

Children's Mental Health
  A. General
  B. Mental Health in Schools
  C. High End
    1. High End - Resources
    2. High End- Research

Should you want additional information check our website or contact the center directly.

Organizations with Resources Relevant to Addressing Barriers to Student Learning

I. Children's Mental Health

A. General

➤Access KEN (The Center for Mental Health Services Knowledge Exchange Network)
P.O. Box 42490, Washington, DC 20015
Phone 1-800-789-CMHS (2647) / **Fax:** 301-984-8796
TDD: 301-443-9006 / **Electronic Bulletin Board System (BBS)**: 1-800-790-CMHS (2647)
Email: ken@mentalhealth.org
Web: http://www.mentalhealth.org/

➤American Academy of Child & Adol. Psychiatry (AACAP)
3615 Wisconsin Ave. N.W.
Washington, DC 20016-3007
Phone (202) 966-7300 / **Fax** (202) 966-2891
Website http://www.aacap.org/
Contact Virginia Anthony, Director

➤American Association on Mental Retardation
444 North Capitol Street, N.W. Suite 846
Washington, DC 20001-1512
Phone (800) 424-3688 / (202)287-1968
Fax (202) 387-2193
Email aamr@access.digex.net
Web site http://www.aamr.org
Contact M. Doreen Croser, Exec. Director

➤American Association of Psychiatric Services for Children
1200-C Scottsville Rd., Suite 225
Rochester, NY 14624
Phone (716) 235-6910 / **Fax** (716) 235-0654
Contact Dr. Sydney Koret, Exec. Director

➤American Council for Drug Education(ACDE)
164 West 74th Street
New York, NY 10023
Phone (212) 595-5810x7860 / **Fax** (212) 595-2553
Contact Martha Gagne

➤American Humane Association
Children's Division
63 Inverness Drive East
Englewood, CO 80112-5117
Phone (303) 792-9900 / **Fax** (303) 792-5333
Website http://www.americanhumane.org
Contact Karen Forested, Director

➤American Orthopsychiatric Association
330 7th Street, 18th Fl.
New York, NY 10001-5010
Phone (212) 564-5930 / **Fax** (212) 564-6180
Email amerortho@aol.com
Website http://www.amerortho.org
Contact Gale Siegel, Director

➤American Psychiatric Association
1700 18th Street, N.W.
Washington, DC 20009
Phone (202) 682-6000 / **Fax** (202) 682-6114
Website http://www.psych.org
Contact Harold Eist, President

➤American Psychological Association
750 First St., N.E.
Washington, DC 20002-4242
Phone (202) 336-5500 / **Fax** (202) 336-6130
Email education@apa.org
Website http://www.apa.org:80

➤ARCH National Resource Center for Crisis Nursery & Respite Health Care Program
800 Eastowne Drive
Chapel Hill, NC 27514
Phone (919) 490-5577 / **Fax** (919) 490-4905
Contact Belinda Broughton, Director

➤Association for Retarded Citizens (ARC-US)
500 East Border Street, Suite 300
Arlington, TX 76010
Phone (817) 261-6003 / **Fax** (817) 277-3491
Contact Alan Abeson, Exec. Director

➤Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002
Phone (202) 467-5730 / **Fax** (202) 223-0409
Email bazelon@nicom.com
Website http://www.bazelon.org
Contact Lee Carty, Director of Communications

➤Board on Children, Youth and Families
Institute of Medicine
National Research Council
2101 Constitution Avenue, NW
Harris 156
Washington, DC 20418
Phone (202) 334-2998/ **Fax** (202) 334-3829
Publications (202) 334-3965
Contact Ann Bridgeman

➤California Institute for Mental Health
Child and Family Center
1119 K Street
Sacramento, CA 95814
Phone (916) 556-3480, Ext. 131 / **Fax** (916) 446-4519
Email kskrabo@cimh.org
Contact Kathie Skrabo, Director

I. Children's Mental Health:

A. General (Cont.)

➤Center for Mental Health Services (CMHS)
Substance Abuse & Mental Health Service Administration
5600 Fishers Lane, Room. 13-103
Rockville, MD 20857
Phone (301) 443-0001 / **Fax** (301) 443-5163
Contact Bernard Arons, Director

➤Consultation Center
Yale University, School of Medicine
389 Whitney Avenue
New Haven, CT 06511
Phone (203) 789-7645 / **Fax** (203) 562-6355
Contact Marsha Kline, Director

➤Council for Children(CEC)
1920 Association Dr.
Reston, VA 22091-1589
Phone (888) CEC-SPED / TTY (703)264-9446
Website http://www.cec.sped.org

➤Frontier Mental Health Services Resource Network
University of Denver
Denver, Colorado 80208-2478
Phone (303) 871-3099 / **Fax** (303) 871-4747
Email jciarlo@du.edu
Website http://www.du.edu:80/frontier-mh/
Contact James Ciarlo

➤Institute for Mental Health Initiatives
4545 42nd. St., NW, Ste. 311
Washington, DC 20016
Phone (202) 364-7111 / **Fax** (202) 363-3891
Email instmhi@aol.com
Contact Michael Benjamin

➤Mental Health Association in L.A. City
1336 Wilshire Blvd.
Los Angeles, CA 90017
Phone (213) 413-1130 / **Fax** (213) 413-1114
Contact Annette Tarsky

➤Mental Health Policy Resource Center
1730 Rhode Island Ave., NW Rm: 308
Washington, DC 20036-3101
Phone (202) 462-9600 / **Fax** (202) 462-9043
Contact Bret Howard, Coor.;
Leslie Scallet, Exec. Director

➤National Alliance for the Mentally Ill (NAMI)
1234 Massachusetts Avenue, NW Suite 721
Washington, DC 20005
Phone (703) 524-7600 / **Fax** (703) 516-7223
Email vanessa@nami.org
Website http://www.nami.org

➤National Association for Rural Mental Health
P.O. Box 570
Wood River, IL 62095
Phone (618) 251-0589 / **Fax** (618) 251-6246
Contact Ed Calahan, President

➤National Association of School Psychologist (NASP)
4340 East West Highway
Suite 402
Bethesda, MD 20814
Phone (301) 657-0270 / **Fax** (301) 657-0275
Email nasp8455@aol.com
Contact William Pfohl, President

➤National Association of Social Workers
750 First Street, NE Suite 700
Washington, DC 20002-4241
Phone (800) 638-8799 / **Fax** (202) 408-8600
Wbsite http://www.nau.edu:80/~socialogy/
social/socialwork/naswi.html

➤Natl. Center for Children's Mental Health Educ.
Campaign
Off. of External Liaison / Center for Mental Health Services
Substance Abuse & Mental Health Service Administration
5600 Fishers Lane, Room. 13-103
Rockville, MD 20857
Phone (301) 443-9848 / **Fax** (301) 443-5163

➤National Center for Mental Health
1021 Prince Street
Alexandria, VA 22314
Phone (703)684-7722

➤National Clearinghouse for Alcohol and Drug
Information
P.O. Box 2345
Rockville, MD 20847-2345
Phone (800) 729-6686 / **Fax** (301) 468-6433
Website http://www.health.org/
Contact John Noble, Director;
Maria Kaczmarek

➤National Clearinghouse on Child Abuse and Neglect Info.
P.O. Box 1182
Washington, DC 20013
Phone (800) 394-3366 / **Fax** (703) 385-3206
Email nccanch@calib.com
Website http://www.calib.com/nccan
Contact Candy Hughes, Program Director

➤National Coalition of Hispanic Health and Human
Services Organizations (COSSMHO)
1501 16th Street, N.W.
Washington, DC 20036
Phone (202) 387-5000 / **Fax** (202) 797-4353
Contact Jane L. Delgado, President - CEO

I. Children's Mental Health:
A. General (Cont.)

➤National Consortium for Child Mental Health Services
1424 16th St., N.W.
Washington, DC 20036
Contact Patricia Jutz
Phone (202) 966-7300 / **Fax** (202) 966-2891

➤National Council of Community Mental Health Centers (NCCMHC)
12300 Twinbrook Pkwy., #320
Rockville, MD 20852
Phone (202) 842-1240 / **Fax** (202) 881-7159
Contact Charles Ray

➤National Council on Alcoholism and Drug Dependency for Los Angeles (NCADD-LA)
3250 Wilshire Ste.2204
Los Angeles, CA 90010
Phone (213) 384-0403 / **Fax** (213) 384-5432
Contact Terry Hays, Director

➤National Council on Alcoholism and Drug Dependency of Union County, Inc.
300 North Avenue East
Westfield, NJ 07090
Phone (908) 233-8810 / **Fax** (908) 233-8932
Contact Pat Ward

➤National Empowerment Center
20 Ballard Road
Lawrence, Massachusetts 01843
Phone (800) 769-3728 / **Fax** (508) 681-6424

➤National Institute of Mental Health (NIMH)
National Clearinghouse for Mental Health Info. (NCMHI)
5600 Fishers Lane
Rockville, MD 20857
Phone (301) 443-4513 / **Fax** (301) 443-4279
Website http://www.nimh.nih.gov/publicat/
Contact Anthony Strong, Information Specialist

➤National Maternal and Child Health Clearinghouse
8201 Greensboro Drive, Suite 600
McLean, VA 22102-3810
Phone (703) 821-8955 / **Fax** (703) 821-2098

➤National Mental Health Association
Publications Division
1021 Prince St.
Alexandria, VA 22314-2971
Phone (703) 684-7722 / **Fax** (703) 684-5968
Email NMHAinfo@aol.com
Contact Ann Utley, President

➤National Mental Health Consumers' Self Help Clearinghouse (NMHCSHC)
311 S. Juniper Street, Rm 1000
Philadelphia, Pennsylvania 19107
Phone (800) 553-4539 / **Fax** (215) 735-0275
Contact Jerry Anter, Program Director

➤National Resource Center on Child Sexual Abuse
National Children's Advocacy Center
2204 Whitesburg Dr.
Huntsville, AL 35801-4546
Phone (205) 534-6868 / **Fax** (205) 534-6883
Contact Cindy Miller, Information Services Specialist

➤New York University Child Study Center
550 First Avenue
New York, NY 10016
Phone (212) 263-6622 / **Fax** (212) 263-0484

➤Society of Professors of Child & Adolescent Psychiatry (SPCAP)
3615 Wisconsin Avenue N.W.
Washington, DC 20016-3007
Phone (202) 966-7300
Contact Martin Drell, President

➤Yale University Child Study Center
230 S. Frontage Road -- PO Box 207900
New Haven, CT 06520-7900
Phone (203) 785-2546 / **Fax** (203) 785-6106
Contact James Comer, Director; Mary Schwab-Stone

➤Youth Development Information Center
10301 Baltimore Blvd.
Beltsville, MD 20705
Phone (301) 504-5719 / **Fax** (301) 504-5472
Contact John Kane, Director

B. Mental Health in Schools

➤Arizona Prevention Resource Center (APRC)
641 E. Van Buren Street, Suite B2
Phoenix, AZ 85004-2337
Phone (602) 727-2772 / **Fax** (602) 727-5400
Contact Chris McIntier

➤Center for Psychology in Schools and Education
750 1st Street, NE
Washington, DC 20002
Phone (202) 336-6126 / **Fax** (202) 335-5962

➤Center for School Mental Health Assist.
Department of Psychiatry / Univ. of Maryland, Baltimore
680 West Lexington Street, 10th Floor
Baltimore, MD 21201-1570
Phone (888) 706-0980 / **Fax** (410) 706-0984
Email csmha@csmha.ab.umd.edu
Contact Mark Weist, Co-Director;
Patrick Myers, Staff Consultant;
Marcia Glass-Siegel, Project Coordinator

➤National Dropout Prevention Center
Publications Department, Clemson University
Clemson, SC 29634-5111
Phone (864) 656-2599 / **Fax** (864) 656-0136
Email ndpc@clemson.edu
Website http://www.dropoutprevetion.org
Contact Jay Smink, Executive Director

➤National Technical Assistance Center (NTAC)
for State Mental Health Planning
Nat. Association of State Mental Health Prog. Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314
Phone (703) 739-9333 / **Fax** (703) 548-9517
Website http://www.nasmhpd.org:80/ntac/

➤Prevention First
2800 Montvale Drive
Springfield, IL 62704
Phone (217) 793-7353 / **Fax** (217) 793-7354
Contact Laurie Carmody, President

➤UCLA Center for Mental Health in Schools
Department of Psychology
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, CA 90095-1563
Phone (310) 825-3634 / **Fax** (310) 206-8716
Email smhp@ucla.edu
Web www.lifesci.ucla.edu/psych/mh/
Contact Howard Adelman or
Linda Taylor, Co-Directors

➤US Dept. of Educ.: Safe and Drug-free Schools Office
Office of Educational Research and Improvement
National Library of Education
555 New Jersey Ave. NW, Rm. 214b
Washington, DC 20208-5725
Phone (202) 219-1547 / **Fax** (202) 219-1817
Website http://www.ed.gov/DrugFree/

C.1. High End - Resources

➤Center for Effective Collaboration and Practice
American Institutes for Research
1000 Thomas Jefferson St. NW Suite 400
Washington, D.C. 20007
Phone: (202)944-5300 / **Fax:** (202)944-5455
Website: http://www.air-dc.org/cecp/

➤Center for Minority Special Education
Hampton University
P.O. Box 6107
Hampton, VA 23668
Phone (804) 727-5100 / **Fax** (804) 727-5131
Email cmse@cs.hampton.edu
Contact Pamela Reilly

➤Center for Psychiatric Rehabilitation
Boston Univ. Psychiatric Rehabilitation Center
930 Commonwealth Avenue
Boston, Massachusetts 02215
Phone (617) 353-3550 / **Fax** (617) 353-7700
Email erogers@bu.edu
Website http://www.bu.edu/SARPSYCH/about.html

➤Center for Special Education Finance (CSEF)
American Institutes for Research
1791 Arastradero Road
P.O. Box 1113
Palo Alto, CA 94302
Phone (415) 493-3550 / **Fax** (415) 858-0958
Email jwolman@air-ca.org
Website http://lists.air-dc.org/csef_hom/

➤Children's Mental Health Service Research Center
Office of the Dean University of Tennessee
College of Social Work
128 Henson Hall
Knoxville, TN 37996-3333
Phone (423) 974-1707 / **Fax** (423) 974-1662
Contact Denny Dukes, Associate Director

I. Children's Mental Health (Cont.)
C.1. High End - Resources

➤Consortium on Inclusive School Practices
Child and Family Studies Program
Allegheny-Singer Research Institute
320 East North Avenue
Pittsburgh, PA 15212
Phone (412) 359-1600 / **Fax** (412) 359-1601
Email salisbu@asri.edu
Website http://www.asri.edu/cfsp

➤East Desk: Knowledge Production and Linkages
Alliance 2000 Project
10860 Hampton Rd.
Fairfax Station, VA 22039-2700
Phone (703) 239-1557 / **Fax** (703) 503-8627

➤Exceptional Children's Assistance Center
P.O. Box 16
Davidson, NC 28036
Phone (800) 962-6817 / **Fax** (704) 892-5028

➤Federal Resource Center for Special Education (FRC)
Academy for Educational Development
1875 Connecticut Avenue NW Ste 900
Washington DC 20009
Phone (202) 884-8215 / **Fax** (202) 884-8443
Email frc@aed.org
Web http://www.aed.org/special.ed/frc.html
Contact Carol Valdivieso, Director Great Lakes Area

➤Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314
Phone (703)684-7710

➤ Regional Resource Center (GLARRC)
Center for Special Needs Populations
The Ohio State University
700 Ackerman Road Ste 440
Columbus, OH 43202
Phone (614) 447-0844 / **Fax** (614) 447-9043
Email Magliocca.l@osu.edu
Webhttp://www.csnp.ohio-state.edu/glarrc/NEWSVIN2.HTM
Contact Larry Magliocca, Director

➤Mid-South Regional Resource Center (MSRRC)
Interdisciplinary Human Development Institute
University of Kentucky
126 Mineral Industries Building
Lexington, KY 40506-0051
Phone (606) 257-4921 / **Fax** (606) 257-4353
Email MSRRC@ihdi.ihdi.uky.edu
Web http://ihdi.ihdi.uky.edu/MSRRC.html
Contact Ken Olsen, Director

➤Mountain Plains Regional Resource Center
Utah State University
1780 North Research Parkway, Ste.112
Logan, UT 84341
Phone (801) 752-0238 / **Fax** (801) 753-9750
Email latham@cc.usu.edu
Contact John Copehaver, Director

➤Mountain Plains Regional Resource Center (MPRRC)
Drake Office
26th and University, Memorial Hall 3rd Floor
Des Moines, IA 50311
Phone (515) 271-3936 / **Fax** (515) 271-4185
Email gary_dennenbring@qmbridge.drake.edu
Website http://www.usu.edu/~mprrc/
Contact Gary Dannenbring

➤National Association of State Mental Health Program Directors (NASMHPD)
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Phone (703) 739-9333 / **Fax** (703) 548-9517
Email andrea.sheerin@nasmhpd
Website http://www.nasmhpd.org
Contact Andrea Sheerin, Information Specialist

➤National Center on Educational Outcomes (NCEO)
University of Minnesota, 350 Elliot Hall
75 East River Road
Minneapolis, MN 55455
Phone (612) 626-1530 / **Fax** (612) 624-0879
Email scott027@maroon.tc.umn.edu
Website http://www.coled.umn.edu/nceo

➤National Center to Improve Practice (NCIP)
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02158-1060
Phone (617) 969-7100 / **Fax** (617) 969-3440
Email ncip@edc.org
Website http://www.edc.org/fsc/ncip/

➤National Technical Assistance Center for Children's Mental Health
Georgetown University-Child Development Center
3307 M Street, N.W., Fourth Floor
Washington, DC 20007-3935
Phone (202) 687-5000 / **Fax** (202) 687-8899
Email gucdc@medlib.georgetown.edu
Website http://www.dml.georgetown.edu/
depts/pediatrics/gucdc/index.html
Contact Joan Dodge and Jan McCarthy,
Senior Policy Associates

➤North Carolina Regional Educational Lab
1900 Spring Rd., Suite 300
Oak Brook, IL 60521
Phone (800) 356-2735 / **Fax** (630) 571-4716

➤Technical Assistance Center for the Evaluation of
Children's Mental Health Systems
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone (617) 232-4125 / **Fax** (617) 232-4125
Email jbcctac@aol.com
Website http://pie.org/T3632
Contact Christina Crowe, Director

C.2. High End Research

➤Center for Continuing Education in Adolescent Health
3333 Burnet Avenue, PAV 2-129
Cincinnati, Ohio 45229-3039
Phone (513) 636-4681 / **Fax** (513) 636-7844
Contact Linda Wildey, Project Coordinator

➤Center for Research on the Education of Students Placed at Risk (CRESPAR)
Johns Hopkins University
3505 N. Charles Street
Baltimore, MD 21218
Phone (410) 516-8809 / **Fax** (410) 516-8890
Contact Lawrence Dolan

➤Center for the Study and Teaching of At-Risk Students
University of Washington (C-Stars)
4725 30th Avenue NE, GG-12
Seattle, WA 98105-4021
Phone (206) 543-3185 / **Fax** (206) 685-4722
Email alsmith@u.washington.edu
Contact Albert Smith, Director

➤Institute for the Study of Students At Risk
University of Maine, College of Education
57666 Shibles Hall
Orono, ME 04469-5766
Phone (207) 581-2440 / **Fax** (207) 581-2423
Contact William Davis

➤National Center to Improve the Tools of Educ. (NCITE)
College of Education / University of Oregon
805 Lincoln
Eugene, OR 97401
Email douglas_carnine@ccmail.uoregon.edu

➤Natl. Early Childhood Techn. Assist. Syst. (NECTAS)
Frank Porter Graham Child Development Center
University if North Carolina at Chapel Hill
500 Nation Bank Plaza
137 East Franklin Street
Chapel Hill, NC 27514
Phone (919) 962-2001 / **Fax** (919) 966-4041
Email nectasta.nectas@mhs.unc.edu
Website http://www.nectas.unc.edu/
Contact Nancy Guadagno, Publications Coordinator

➤Natl. Info. Center for Children & Youth w/ Disabilities
P.O. Box 1492
Washington, DC 20013
Phone (800) 999-5599 / **Fax** (703) 893-1741
Website http://www.aed.or/nichcy/

➤National Institutes of Health (NIH)
Neurological Institute
P.O. Box 5801
Bethesda, MD 20824
Phone (800)352-9424
Website http://www.nih.giv
Email nihinfo@od.nih.gov

➤National Research and Training Center on
Psychiatric Disability and Peer Support
104 South Michigan Avenue, Suite 900
Chicago, Illinois 60603
Phone (312) 422-8180 / **Fax** (312) 422-0740
Contact Judith A. Cook, Director

➤National Resource Network on Child &
Family Mental Health Services
Washington Business Group on Health
777 North Capitol Street, NE, Suite 800
Washington, DC 20002
Phone (202) 408-9320 / **Fax** (202) 408-9332

➤Natl. Transition Alliance for Youth with Disab. (NTA)
(National Transition Network, Academy for Educational
Development, Transition Research Institute, TRI)
University of Illinois, 113 Children's Research Center
51 Gentry Drive
Champaign, IL 61820
Phone (217) 333-2325 / **Fax** (217) 244-0851
Email leachlyn@ux1.cso.uiuc.edu
Website http://www.ed.uiuc.edu/coe/sped/tri/institute.html

➤National Transition Network (NTN)
University of Minnesota, 430 Wulling Hall
86 Pleasant Street SE
Minneapolis, MN 55455
Phone (612) 626-8200 / **Fax** (612) 626-7956

I. Children's Mental Health (Cont.)
C.2. High End - Research

➤Networking Syst. for Training Educ. Personnel (NSTEP)
National Association of State Directors of Education
1800 Diagonal Road, Ste. 320
Alexandria, VA 22314
Phone (703) 519-3800 / **Fax** (703) 519-3808
Email patgonz@nasdse.org
Contact Patricia Gonzalez

➤Northeast Regional Resource Center (NERRC)
Trinity College of Vermont, McAuley Hall
208 Colchester Avenue
Burlington VT 05401-1496
Phone (802) 658-5036 / **Fax** (802) 658-7435
Email NERRC@aol.com
Web http://interact.uoregon.edu/wrrc/nerrc/index.htm
Contact Pamela Kaufmann, Director

➤Project FORUM
Natl. Association of State Directors of Special Education
1800 Diagonal Road Ste. 320
Alexandria, VA 22314
Phone (703) 519-7008 / **Fax** (703) 519-3808
Email eahearn@nasdse.org

➤Research & Training Center for Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
Phone (813) 974-4661 / **Fax** (813) 974-4406
Contact Bob Friedman, Director

➤Research and Training Center on Family Support and Children's Mental Health
Portland State University
P.O. Box 751
Portland, OR 97207-0741
Phone (503) 725-4040 / **Fax** (503) 725-4180
Website http://www.adm.pdx.edu/user/rri/rtc
Contact Barbara Friesen

➤South Atlantic Regional Resource Center (SARRC)
Florida Atlantic University
1236 North University Drive
Plantation, FL 33322
Phone (954) 473-6106 / **Fax** (954) 424-4309
Email SARRC@acc.fau.edu
Web http://www.fau.edu/admin/a-n-f/sarrc.htm
Contact Tim Kelly, Director

➤Technical Assistance Center for Professional Devel. Partnership Projects
Academy for Educational Development
1875 Connecticut Avenue, NW Ste 800
Washington, DC 20009-1202
Phone (202) 884-8209 / **Fax** (202) 884-8443
Email pdp@aed.org
Website http://aed.org/special.ed/prodevel/index.html

➤Technical Assistance for Parent Programs (TAPP)
Federation for Children with Special Needs
95 Berkeley Street Ste 104
Boston, MA 02116
Phone (617) 482-2915 / **Fax** (617) 695-2939
Email johns006@maroon.tc.umn.edu
guyxx002@maroon.tc.umn.edu
Website http://www.fcsn.org:80/tapp/

➤Technology, Educational, Media, and Materials Program
Chesapeake Institute
100 Thomas Jefferson Street NW Ste 400
Washington, DC 20007
Phone (202) 342-5600 / **Fax** (202) 944-5454
Email dosher@air-dc.org

➤West Desk: Technical Assistance
Alliance 2000 Project
College of Education, Room 223
University of New Mexico
Albuquerque, NM 87131-1236
Phone (800) 831-6134 / **Fax** (505) 277-7228

➤Westat, Inc.
Technical Assistance in Data Analysis, Evaluation, and Report Preparation
1500 Research Blvd.
Rockville, MD 20850
Phone (301) 738-3668 / **Fax** (301) 294-4475
Email brauenml@westat.com

➤Western Regional Resource Center (WRRC)
1268 University of Oregon
Eugene, OR 97403-1268
Phone (541) 346-0367 / **Fax** (541) 346-5639
Email dls@oregon.uoregon.edu
Website http://interact.uoregon.edu/wrrc/wrrc.html
Contact Richard Zeller, Director

Some Organizations Provide A Range of Materials Covering a Variety of Topics

Here is a sampling of those that do and listings about what they offer

American Academy of Child and Adolescent Psychiatry (AACAP)

AACAP has been a growing and dynamic organization, giving direction to and responding quickly to new developments in the health care environment, and addressing the needs of children, adolescents and families. AACAP has developed numerous publications addressing various issues related to mental health. Some of these publications, which are mostly free, can also be accessed through their website.

Contact: **3615 Wisconsin Avenue, NW • Washington, DC 20016-3007 • Ph: 202-966-7300 • Fax: 202-966-2891 • Website: http://www.aacap.org/**

A list of their publications follows:

- ***Facts for Families***

To help educate parents and families about psychiatric disorders affecting children and adolescents, the AACAP publishes *Facts for Families* - over 54 informational sheets which provide concise and up-to-date material on issues such as the depressed child, teen suicide, helping children after a disaster, discipline, learning disabilities, and child sexual abuse. The fact sheets are available in English, Spanish, and French. Titles include:

- The Adopted Child
- The Anxious Child
- The Autistic Child
- Bed wetting
- Child Abuse - The Hidden Bruises
- Child Sexual Abuse
- The Child with a Long-Term Illness
- Children and AIDS
- Children and Divorce
- Children and Family Moves
- Children and Firearms
- Children and Grief
- Children & Lying
- Children & TV Violence
- Children of Alcoholics
- Children of Parents with Mental Illness
- Children Who Can't Pay Attention
- Children Who Steal
- Children Who Won't Go to School
- Children's Major Psychiatric Disorders
- Children's Sleep Problems
- Conduct Disorders
- The Continuum of Care
- The Depressed Child
- Discipline
- Helping Children After a Disaster
- Home Alone Children
- The Influence of Music and Rock Videos
- Know When to Seek Help for Your Child
- Know Your Health Insurance Benefits
- Lead Exposure

- Guide to Programs for SBHC/SLHCs

  A comprehensive, five-volume resource for advocates or administrators on planning or expanding SBHS/SLHCs. They are:

  - Volume I: Advocating for a School-Based and School-Linked Health Centers
  - Volume II: Designing and Implementing School-Based and School-Linked Health Centers
  - Volume III: Potential Sources of Federal Support for School-Based and School-Linked Health Services
  - Volume IV: Assessing and Evaluating School-Based and School-Linked Health Centers
  - Volume V: Legal Issues Confronting School-Based Health Centers

- How to Use Site-Monitoring Teams to Evaluate School-Based and School-Linked Health Centers
  This is a step-by-step guide for SBHC evaluations. Useful for assessing service delivery in the early stages of a program.

- Advocacy Kits
  I. Adolescent Reproductive and Sexual Health: This kit contains tips on how to advocate for teen health programs, as well as background statistics, resources and sample materials to take your case to the community. Contains two fact sheets.

  II. The SBHC-specific version of the advocacy kit has all the materials of the Health Kit, plus special information for SBHC proponents including public education materials. an analysis of opposition materials and an SBHC Fact Sheet.

- ***Front Line Resources***

- When I'm Grown
  This three-volume resource for young children offers an innovative approach to "life-skills." It covers sexuality, HIV prevention and health information within a comprehensive framework of self-esteem development, problem-solving, healthy peer and family communications, values clarification, goal achievement, and career awareness. Nearly 300 activities mix large/small-group, hands-on discussion exercises and role playing to stimulate self-reflection and critical-thinking skills. Available versions for grades K-12, grades 3-4, grades 5-6.

- Life Planning Education
  Comprehensive health resources include pregnancy/AIDS prevention and sexuality/life skills education for ages 13-18. Can be used in all youth settings.

- Make a Life for Yourself
  A companion to Life planning Education or a stand-alone resource, these workbooks contain thought-provoking and fun activities. Topics include planning for the future and making good choices about school, career and parenthood. For teachers, parents, teens and youth professionals. Includes information on HIV/AIDS.

- Child and Adolescent Psychiatry: Treatment and Insurance Issues, An Information Kit
  This resource addresses the issues facing legislators, insurers, employers and prepaid plans when they need to make decisions regarding how--and to what extent--youngest should be covered for child and adolescent psychiatric treatment. A set of slides to W in presentations to these or other groups is also available. Members: $5.00, Non-Members: $7.00. Set of 20 slides: Members: $12.00, Non-Members: $20.00.

- Child and Adolescent Psychiatric Treatment: Guidelines for Treatment Resources, quality Assurance, Peer Review and Reimbursement.
  This 74-page looseleaf binder provides clear and detailed guidelines for peer review of child and adolescent psychiatric, substance abuse and eating disorder treatment. It describes the role and function of the continuum of treatment resources, and presents facts and recommendations regarding insurance coverage for child and adolescent psychiatric treatment. It also provides criteria for admission and continued stay for various levels of treatment. Hospitals, reviewers and providers should find it useful in their efforts to assure that treatment is medically necessary, appropriate, cost-effective and of adequate quality. Members: $15.00, Non-Members: $30.00.

- Documentation of Medical Necessity of Child and Adolescent Guidelines for use in Managed Care, Third-Party Coverage and Peer Review.
  This 30-page monograph is chapter 4 on criteria for admission and continued treat me from the binder listed above, reprinted in booklet form. It addresses the issues of severity and complexity of illness and the issues of intensity and duration of services required. Substance Abuse and Eating D orders are included. Utilization review programs, insurance companies and managed care systems will find this useful in determining whether treatment is medically necessary and appropriate. Members: $6.00, Non-Members: $12.00.

- Resources for Quality Adolescent Hospitalization Kit.
  This folder, produced by the Academy's Task force on Adolescent Hospitalization, combines policy statements, articles and guidelines to assist providers and others in assuring appropriate hospitalization and quality care for adolescents with serious menta disorders. $ 10.00.

- Office of Clinical Affairs AACAP Managed Care Report
  (edited by Mary Jane England, M.D., and Alan Axelson, M.D.)
  Quarterly newsletter of interest to benefits managers concerning issues in child & adolescent psychiatric treatment. $10.

- **Public Information**

- HIV/AIDS -- Information Sheet-Resource Guide.
  These two documents produced by the AACAP's HIV Issues Committee is a 24-page guide to information for care givers of children and adolescents with HIV/AIDS. Free with self-addressed, large $2.00 stamped envelope. Order: PI-HIV.

- Glossary of Mental Illnesses Affecting Teenagers.
  This brochure/poster defines 17 major mental disorders in clear, concise language. Also provided are a reading list and resource list for further information. Single copy free with self-addressed, large stamped envelope. Quantities: $.50 each. Order: PI-02.

- Questions and Answers about Child Psychiatry.
  This pamphlet provides parents and others with answers to frequently asked questions that arise before consulting with a child and adolescent psychiatrist. Single copy free with self-addressed, stamped envelope. Order: PI-03.

American Psychiatric Association

The American Psychiatric Association is a national medical specialty society whose 40,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

***Contact*: 1700 18th Street, N.W.• Washington, DC 20009 •Ph: (202) 682-6000, Fax- (202) 682-6114 • Website: http://www.psych.org/ (organization) • http://www.appi.org/ (press)**

A list of their publication topics includes:

■ ***Let's Talk Facts About...***

This is a pamphlet series on various topics. Each contains an overview of the illness, its symptoms, and the illness's effect on family and friends. A bibliography and list of resources make it ideal for libraries or patient education. The pamphlet series are available in packets of 50 pamphlets.

- Childhood Disorders
- Teen Suicide
- Panic Disorder
- Eating Disorder
- Schizophrenia
- Choosing a Psychiatrist
- Phobias
- Obsessive-Compulsive Disorder
- Substance Abuse
- Coping with HIV & AIDS
- Mental Illness (An Overview)
- Manic Depressive/Bipolar Disorder
- Post Traumatic Stress Disorder
- Anxiety Disorder
- Depression
- Psychiatric Medication
- Alzheimer's Disease
- Mental Health of the Elderly

■ ***Subject Index***

- Anxiety Disorders
- Childhood Disorders
- Consultation-Liaison Psychiatry
- Cross-Cultural and International Psychiatry
- DSM-IV Library
- Eating Disorders
- Gender-Related Issues
- Geriatric Psychiatry, Alzheimer's Disease, and Dementia
- History and the Future
- Journals
- Law and Ethics
- Managed Care and Economics
- Marriage, Family, and Parenting
- Mood Disorders and Suicide
- Multimedia Products
- Neuropsychiatry and Biological Psychiatry
- Personality Disorders
- Progress in Psychiatry Series
- Psychiatric Hospitalization
- Psychoses
- Psychotherapies and Psychoanalysis
- Religion
- Sexuality
- Somatic Therapies
- Substance Use Disorders
- Textbooks and References
- Titles for the General Public
- Trauma, Violence, Dissociative Disorders, and Posttraumatic Stress Disorder

American Psychological Association (APA)

APA is an excellent source of publications detailing the latest research findings, trends and issues on prevention and clinical interventions of different types of mental health and psychological problems about children, adolescents, families, etc. One of their catalogs *Psychology in the Schools* features the latest books on behavior therapy, violence, understanding aggression, and coercive actions, attention-deficit/hyperactivity disorder, etc. APA's Practice Directorate division also publishes fact sheets which provide answers to common questions about mental health. Some of these fact sheets can be downloaded through their website.

Contact:
750 First Street, NE
Washington, DC 20002-4242
Ph: (202)336-5500;
(202)336-5800
Website: http://www.apa.org/

Book Order Department
P.O. Box 2710
Hyattsville, MD 20784-0710
Ph: (800)374-2721
Fax: (202)336-5502
Website: http://www.apa.org/

Some of their publications include:

- ***Just the Facts***
  - Anxiety Disorders: The Role of Therapy in Effective Treatment
  - How Therapy Helps People Recover from Depression
  - How to Find Help Through Therapy
  - Managing Traumatic Stress
  - APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations

- ***Brochures***

  The Public Affairs Office of the American Psychological Association has prepared several brochures to provide information on mental health and psychological issues that face us all. They're collected into topical groups of work, family and the mind-body connection. You'll also find a list here of state and provincial psychological associations, many of which offer referrals for mental health services, as well as a link to association ethics documents.

  - Work
    - Sexual Harassment: Myths and Realities
  - Family
    - Questions and Answers about Memories of Childhood Abuse
    - Raising Children to Resist Violence: What You Can Do
    - Violence on Television: What Do Children Learn? What Can Parents Do?
    - What Makes Kids Care? Teaching Gentleness in a Violent World
    - Answers to Questions About Sexual Orientation and Homosexuality
  - Mind & Body
    - Finding Help: How to Choose a Psychologist
    - Controlling Anger Before It Controls You
    - What You Should Know About Women and Depression
    - Answers to Questions About Panic Disorder
  - Additional information
    - Information on State and Provincial Psychological Associations
    - APA Ethics Information

The Center for Mental Health Services (CMHS)

CMHS, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), established the Knowledge Exchange Network as a one-stop, national clearinghouse for free information about children's and adolescents' mental health including publications, references, and referrals to local and national resources and organizations. This clearinghouse offers a list of possible partnership activities, campaign information and poster materials, and a series of brochures and fact sheets developed in collaboration with the National Institute of Mental Health.

Contact: Valna Montgomery
Manager, Children's Mental Health Education Campaign
Office of External Liaison, Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 13-103
Rockville, MD 20857
Ph: 301-443-9848; e-mail: vmontgom@samhsa.gov
Fax: 301-443-5163
Website: http://www.mentalhealth.org/

A list of their publications includes the following:

- ***Publications for Young People and Families***
  - **Brochures**
    - Your Child's Mental Health: What Every Family Should Know
    - You and Mental Health: What's the Deal? (for teenagers)
    - Poster (can be used with "You and Mental Health: What's the Deal?)
  - **Fact Sheets**
    - Children's and Adolescents' Mental Health
    - Children's and Adolescents' Mental: A Glossary of Terms
    - Mental, Emotional, and Behavior Disorders in Children and Adolescents (an overview of disorders)
    - Anxiety Disorders in Children and Adolescents
    - Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
    - Autism Spectrum Disorders in Children and Adolescents
    - Conduct Disorder in Children and Adolescents
    - Major Depression in Children and Adolescents
    - National Clearinghouse for Alcohol and Drug Information Order Form
- ***Publications for Providers and Communities***
  - **Fact Sheets**
    - Comprehensive Community Mental Health Services for Children Program (description of CMHS program in 18 States)
    - Systems of Care (coordination of services)
    - Cultural Competence in Serving Children and Adolescents with Mental Health Problems
    - Caring for Every Child's Mental Health: Communities Together Campaign
    - Children's and Adolescent's Mental Health Services Technical Assistance Research Centers

The Council for Exceptional Children

(CEC) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. CEC advocates for appropriate governmental policies, sets professional standards, provides continual professional development, advocates for newly and historically underserved individuals with exceptionalities, and helps professionals obtain conditions and resources necessary for effective professional practice.

Contact: 1920 Association Drive, Reston ● VA 20191-1589 Ph: 1-888-CEC-SPED
FAX: 703-264-9494 Website: http://www.cec.sped.org/

▪ ***Publications and Journals***

- CEC Today Online!: The Web companion for CEC Today readers featuring article supplements and online surveys.
- CEC Journals
  TEACHING Exceptional Children
  Exceptional Children
- Special Web Focus: A collection of resources on topics of importance to special educators.

▪ ***Resource Catalogue: Books and media for the Educator***

- Assessment: Testing, standards, performance assessment, test-taking skills
- Instruction: Teaching strategies and techniques, curriculum adaptation, teaching social skills
- Early Childhood: Early intervention, quality programs, nurturing giftedness
- Emotional/Behavior Disorders/At-Risk/Autism: Teaching and intervention strategies, behavior and classroom management, programs
- Gifted: Teaching techniques, curriculum, college planning
- Inclusion: Understanding individual differences, model programs, cooperative teaching, using paraeducators, providing safe schools, cultural diversity
- Law and Special Education Administration: IDEA, Section 504, IEPs, suspension, advocacy, grants, federal budget
- LD/ADD: Guides, teaching strategies and techniques, inclusion
- Professional Enrichment: Survival guide, professional preparation, standards, teacher education
- Transition: Life Centered Career Education, self-determination, career planning resources, IEPs

▪ ***Special Projects*: CEC manages a number of grants, contracts, and research projects, including:**

- ERIC Clearinghouse on Disabilities and Gifted Education
- National Clearinghouse on Professions in Special Education
- Culturally & Linguistically Appropriate Services Early Childhood Research Institute
- National Plan for Training Personnel to Serve Children with Blindness and Low Vision
- Beacons of Excellence: Achieving Exemplary Results for Students with Disabilities in Secondary Education
- National Institute on Comprehensive System of Personnel Development

National Association of School Psychologists (NASP)

NASP publishes books, booklets, fact sheets, and CD rom that contain information and resources on different mental health issues in school settings. Their publications are created for a wide range of audience such as researchers, faculty, practitioners, teachers, and parents. Examples of the topics covered are intelligence and personality assessment, home-school collaboration, alternative educational delivery systems, interventions for achievement and behavioral problems, children at risk, etc.

Contact: 4340 East West Highway, Suite 402
Bethesda, MD 20814
Ph: 301/657-0270
Fax: 301/657-0275
E-mail: nasp8455@aol.com
Website: http://www.uncg.edu/~erriccas2/nasp/

A list of some of NASP publications include the following:

- ***Fact Sheets***

  - Children and Household Chores
  - Children and Organizational Skills
  - Children and Responsibility
  - Children and Study Skills
  - Children and Depression
  - Children and Dependency
  - Children and Masturbation
  - Shyness

- ***Best Practices III on CD-ROM***

  This offers ready access to the entire text of NASP's best-selling Best Practices in School Psychology III through your home or office computer!

  Find any chapter, author, book or subject almost instantly using the powerful but easy-to use FolioViews (r) infobase software.

  Search individual words, phrases or names quickly and efficiently. Use logical operators such as AND, OR, NOT and XOR to narrow your search. Need to know every single place in Best Practices where "CBM" and "reading" are referenced together? This CD will quickly show you all 39 occurances and take you to each with one click of your mouse.

  Print highlighted text for instant handouts. You can also export text to your word processing program to create research papers, course materials, parent/teacher handouts, bibliographies, worksheets and more. This saves time and makes presentation materials more professional looking.

  Customize your Best Practices with personal annotations. Flag up to 1000 key sections with individually named bookmarks, highlight text in hundreds of different colors and styles for easy reference, and write pop-up notes up to 4,000 characters long.

National Association of Social Workers (NASW)

NASW Press, a dissemination arm of NASW, is a leading scholarly press in the social sciences. It serves faculty, practitioners, agencies, librariers, clinicians, and researchers throughout the United States and abroad. NASW Press delivers professional information to more than 250,000 readers through its scholarly journals, books, and reference works.

Contact: 750 First St., N.E., Suite 700, Washington, D.C. 20002-4241
Ph: 800-638-8799; 202/408-8600 / Fax: 202/336-8310
Website: http://www.naswpress.org/

Titles of their publications are as follows:

- ***Children and Families***
  - Caring Families: Supports and Interventions (Deborah S. Bass)
  - Helping Vulnerable Youths: Runaway and Homeless Adolescents in the United States (Deborah S. Bass, Prinicipal Investigator)
  - Painful Passages: Working with Children with Learning Disabilities (Elizabeth Dane)
  - Research on Children (Shirley Buttrick, Editor)
  - Training Videos: The Swan Sisters, State v. Swan, and the Williamson Case (Parts I & II) (Donald Dickson, Producer)
  - The Vulnerable Social Worker: Liability for Serving Children with Families (Douglas J. Besharov)
- ***Clinical Practice***
  - Clinical Social Workers
  - Managed Care Resource Guide for Social Workers in Private Practice (Vivian H. Jackson)
  - Managed Care Resource Guide for Social Workers in Agency Settings (V. Jackson, ed.)
  - More than a Thousand Words: Graphics for Clinical Practice (Mark A. Mattaini)
  - NASW Guidelines on the Private Practice of Clinical Social Work
  - Person-in-Environment System (James M. Karls and Karin E. Wandrei, Editors)
  - Social Work in Private Practice, 2nd Edition (Robert L. Barker)
  - Third-Party Reimbursement for Clinical Social Work Services
  - Visual EcoScan for Clinical Practice (Developed by Mark A. Mattaini)
- ***Diversity***
  - Color in a White Society (Barbara W. White, Editor)
  - The Diverse Society: Implications for Social Policy (Pastora San Juan Cafferty and Leon Chestang, Editors)
  - Ethnicity & Race: Critical Concepts in Social Work (Carolyn Jacobs and Dorcas D. Bowles, Editors)
  - The Helping Tradition in the Black Family and Community (E. P. Martin & J. M. Martin)
  - Lesbian and Gay Issues: A Resource Manual for Social Workers (Hilda Hidalgo, Travis Peterson, and Natalie Woodman, Editors)
  - Multicultural Issues in Social Work (Patricia L. Ewalt, Edith M. Freeman, Stuart A. Kirk, and Dennis L. Poole, Editors)
  - Social Work and the Black Experience (Elmer P. Martin and Joanne Mitchell Martin)
  - Health and Mental Health
  - AIDS: Helping Families Cope

National Information Center for Children and Youth with Disabilities (NICHCY)

NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators, and other professionals. Special focus is given to children and youth (birth to age 22). NICHCY also provides other services such as: personal responses to questions on disability issues, including specific disabilities, early intervention, special education, family issues, legal issues, Individual Education Programs, and much more; referrals to other organizations and agencies, including national and state disability groups, regional and state organizations, professional associations, information centers, parent groups, and advocacy groups; information searches of NICHCY's Databases and Library; and technical assistance to parent and professional groups.

Most of the printed publications of NICHCY are accessible at their internet site and can be printed out free of charge. Publications available in Spanish are indicated with an asterisk (*). A complete list of their publications is as follows:

- ***General Resource Publications***

  - NICHCY brochure describes their services. Free of charge.
  - National Resources gives the numbers and addresses of selected national organizations and information centers that deal with various disabilities or that can provide information about disabilities. 4 pages. Free of charge. Single copies only.
  - General Information About Disabilities* gives an overview of the 13 disabilities defined by the Individuals with Disabilities Education Act. 2 pages. Free of charge. Single copies.
  - Public Agencies Fact Sheet gives a general description of public agencies that assist families of children with disabilities. 2 pages. Free of charge. Single copies only.
  - National Toll-Free Numbers gives the toll-free numbers of selected national organizations addressing disabilities. 6 pages. Free of charge. Single copies only.
  - State Resource Sheet gives a list of selected state-wide disability-related agencies and organizations in your state, including public agencies and specific disability organizations. 4 pages. Free of charge. Single copies only.
  - Complete Set of State Resource Sheets includes a state resource sheet for each state and territory within the United States. 105 pages. $10.00.
  - NICHCY SPANISH PUBLICATIONS CATALOG describes all NICHCY publications available in Spanish. 8 pages. Free of charge.

National Maternal and Child Health Clearinghouse

The Clearinghouse is funded by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB). It disseminates state-of-the-art information about maternal and child health in response to requests from Federal, State, and local agencies; educators; health professionals; policy makers and program planners; researchers; voluntary organizations; and the general public. In addition to publications for professionals, the Clearinghouse offers patient education materials in English and in the following other languages: Cambodian, Chinese, Haitian Creole, Korean, Laotian, Samoan, Spanish, Tagalog, Thai and Vietnamese. The Maternal and Child Health Publications catalog can be viewed through MCH-Netlink on their website.

Contact: 2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
Ph: (703) 821-8955
Fax: (703) 821-2098
Website: http://www.ichp.ufl.edu/

A list of their publications is as follows:

■ *Child and Adolescent Health*

- Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents - Brochure (*National Center for Education in Maternal and Child Health*. 1995).
  This brochure consists of comprehensive health supervision guidelines for health and education professionals who confront the "new morbidities" that challenge children, adolescents, families, and communities.

- Sources of Consumer Health Information: Bibliography of Selections from the NCEMCH Reference Collection and Database of Organizations, June 1995 (*National Center for Education in Maternal and Child Health*. 1995).
  This bibliography lists directories, resource guides and source books of consumer health information, including foreign language material, and is organized into eight categories including general; chronic illnesses/disabling conditions; cultural diversity; infant and child health; injury/violence prevention; nutrition; sexuality education; and women's health. This item also includes organizations that provide consumer education materials; $5.00.

- Promoting Mental Health in Early Child Care Settings - Proceedings of the Second Annual UCLA National Conference on Preventive Psychiatry, 1988 (*University of California at Los Angeles*. 1989).

- Children's Safety Network: A Resource for Child and Adolescent Injury and Violence Prevention - Brochure (*National Center in Maternal and Child Health*. 1995).

- Consortium of Clearinghouses on Child Abuse and Neglect, Second Edition (*National Clearinghouse on Child Abuse and Neglect Information*. 1994).

- Responding to Child Abuse and Neglect: A Continuing Challenge (*University of Pittsburgh School of Public Health*. 1993).

- Violence: The Impact of Community Violence on African American Children and Families (*National Center for Education in Maternal and Child Health*. 1992).
  This document summarizes a conference co-sponsored by the MCHB and the Child and Adolescent Service System Program (formerly part of the National Institute of Mental Health) and explores how various systems could develop common understandings of the problem and strategies for collaboration; $9.50 with bulk prices available.

National Technical Assistance Center for Children's Mental Health

The National Technical Assistance Center for Children's Mental Health, formerly the CASSP Technical Assistance Center, assists states and communities in developing a system of care for children with, or at risk for, serious emotional or behavioral disorders and their families. Special areas of emphasis include: family involvement, interagency collaboration, financing, cultural competence, early intervention, and outreach. The center operates a resource data bank of practical tools, best practices, national experts; offers a World Wide Web site (http://www.dml.georgetown.edu/depts/pediatrics/gucdc/index.html/) and publication list; facilitates peer consultation; and sponsors a bi-annual training institute. It is funded through a cooperative agreement among the Maternal and Child Health Bureau of HRSA, the Center for Mental Health Services of SAMHSA, and the Administration for Children, Youth, and Families, U.S. DHHS.

Contact: Georgetown University - Child Development Center
3307 M Street, N.W., Fourth Floor
Washington, DC 20007-3935
Ph: (202) 687-5000
Fax: (202) 687-8899; Email: gucdc@medlib.georgetown.edu
Website: http://www.dml.georgetown.edu/depts/pediatrics/gucdc/index.html/

A list of technical assistance documents available includes:

- ***System of Care/CASSP***
- Lessons Learned from the Fort Bragg Demonstration: An Overview, 1996 (by Sheila Pires)
- Systematic Approaches to Mental Health Care in the Private Sector for Children, Adolescents, and Their Families: Managed Care Organizations and Service Providers, 1996 (by Ira S. Lourie, S.W. Howe, and Linda L. Roebuck)
- Families at the Center of the Development of a System of Care, 1996 (by Naomi Tannen)
- Managed Care and Children's Mental Health: Summary of the May, 1995 State Managed Care Meeting, 1996 (by Beth Stroul)
- Resources for Staffing Systems of Care for Children with Emotional Disoders and Their Families, 1995 (by Sheila Pires)
- Principles of Local System Development for Children, Adolescents and Their Families, 1994 (By Ira S. Lourie)
- Systems of Care for Children and Adolescents with Severe Emotional Disturbances: What are the Results?, 1993 (by Beth A. Stroul)
- One Kid at a Time: Evaluative Case Studies and Description of the Alaska Youth Initiative • Demonstration Project, 1993 (by J. Burchard, S. Burchard, R. Sewell & J. VanDenBerg)
- Profiles of Local Systems of Care for Children and Adolescents with Severe Emotional Disturbances, 1992 (by B. Stroul, I.S. Lourie, S.K. Goldman, & J. Katz-Leavy)
- Individualized Services in a System of Care, 1992 (by J. Katz-Leavy, I.S. Lourie, B. Stroul & C. Zeigler-Dendy)
- State Child Mental Health Planning, 1991 (by Sheila Pires).
- Sizing Components of Care: An Approach to Determining the Size and Cost of Service Components in a System of Care for Children and Adolescents with Serious Emotional Disturbances, 1990 (by S. Pires)
- Final Repport, The CASSP Initial Cohort Study, Volume I: Cross-Site Findings, 1990 (by W.E. Schlenger, R.M. Etheridge, D.J. Hansen & D.W. Fairbank)
- Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed, Volume I: Home-Based Services, 1988 (by B. Stroul)
- Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed, Volume II: Home-Based Services, 1988 (by B. Stroul)
- Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed, Volume III: Therapeutic Foster Care, 1989 (by B. Stroul)

National Institute of Mental Health (NIMH)

The National Institute of Mental Health (NIMH) conducts and supports research nationwide on mental illness and mental health, including studies of the brain, behavior, and mental health services. NIMH is a part of the National Institutes of Health (NIH), the principal biomedical and behavioral research agency of the United States Government. NIH is a component of the U.S. Department of Health and Human Services. NIMH is dedicated to improving the mental health of the American people; fostering better understanding, diagnosis, treatment, and rehabilitation of mental and brain disorders; and preventing mental illness.

NIMH offers a variety of publications to help the general public gain a better understanding of mental disorders. The following publications offer an array of information, written in easy-to-understand language, on mental health and mental disorders. Most of the publications are free and can be downloaded from their website, as well.

Contact: NIMH Information Resources and Public Inquiries
5600 Fishers Lane, Rm 7C-02
Rockville, MD 20857
Ph: 301-443-4513
Fax: 301-443-4279
Website: http://www.nimh.nih.gov/publicat/

Topics include:

- ***Information on Specific Mental Disorders, Their Diagnosis and Treatment***

  You will find discussions of symptoms, diagnosis, and treatment, as well as information on how and where to find help. Also discussed is research that is yielding information about the causes of mental disorders and hope for the future through the development of new therapies.

  These materials are in the public domain and can be downloaded, reproduced, or copied without permission. Citation of the source is always appreciated.

  - Anxiety Disorders
  - Obsessive-Compulsive Disorder
  - Panic Disorder
  - Getting Treatment for Panic Disorder
  - Panic Disorder Treatment and Refererral
  - Understanding Panic Disorder
  - Depression
  - Bipolar Disorder
  - Depression: Effective Treatments Are Available
  - If You're Over 65 and Feeling Depressed
  - Lets Talk About Depression
  - Plain Talk About Depression
  - Alzheimer's Disease
  - Attention Deficit Hyperactivity Disorder
  - Eating Disorders
  - Learning Disabilities
  - Medications
  - Schizophrenia Q & A
  - You Are Not Alone

- ***Publicaciones en Espanol*** *(Publications in Spanish)*

  - Trastornos de Ansiedad (Anxiety Disorder)
  - Trastorno de Panico (Panic Disorder)

- ***Mental Illness in America***

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* See references in previous excerpted articles.

C. Relevant Center Materials

UCLA Center for Mental Health in Schools

SOME SPECIAL RESOURCES FROM THE CLEARINGHOUSE

The mission of the Center is to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools in schools.

Under the auspices of the School Mental Health Project in the Department of Psychology, our Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given to policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

A partial list...

I. Introductory Packets

Working Together: From School-Based Collaborative Teams to School-Community-Higher Education Connections

This packet discusses the processes and problems related to working together at school sites and in school-based centers. It also outlines models of collaborative school-based teams and interprofessional education programs*.

Violence Prevention and Safe Schools

This packet outlines selected violence prevention curricula and school programs and school-community partnerships for safe schools. It emphasizes both policy and practice.

Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs

This packet highlights the principle of *least intervention needed* and its relationship to the concept of *least restrictive environment*. From this perspective, approaches for including students with disabilities in regular programs are described.

Parent and Home Involvement in Schools

This packet provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Assessing to Address Barriers to Learning

This packet discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on procedures and instruments to measure psychosocial, as well as environmental barriers to learning.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Cultural Concerns in Addressing Barriers to Learning

This packet highlights concepts, issues and implications of multiculturalism/cultural competence in the delivery of educational and mental health services, as well as for staff development and system change. It also includes resource aids on how to better address cultural and racial diversity in serving children and adolescents.*

Dropout Prevention

This packet highlights intervention recommendations and model programs, as well as discusses the motivational underpinnings of the problem.*

Learning Problems and Learning Disabilities

This packet identifies learning disabilities as one highly circumscribed group of learning problems, and outlines approaches to address the full range of problems.*

Teen Pregnancy Prevention and Support

This packet covers model programs and resources and offers an overview framework for devising policy and practice.*

II. Resource Aid Packets

Screening/Assessing Students: Indicators and Tools

This packet is designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.*

Responding to Crisis at a School

This packet provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. It contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training, and as information handouts for staff, students, and parents.*

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs

This packet provides surveys covering six program areas and related system needs that constitute a comprehensive, integrated approach to addressing barriers and thus enabling learning. The six program areas are (1) classroom-focused enabling, (2) crisis assistance and prevention, (3) support for transitions, (4) home involvement in schooling, (S) student and family assistance programs and services, and (6) community outreach for involvement and support (including volunteers).*

Students and Psychotropic Medication: The School's Role

This packet underscores the need to work with prescribers in ways that safeguard the student and the school. It contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Substance Abuse

This packet offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. It also includes some assessment tools and reference to prevention resources.*

Clearinghouse Catalogue

Our Clearinghouse contains a variety of resources relevant to the topic of mental health in schools. This annotated catalogue classifies these materials, protocols, aids, program descriptions, reports, abstracts of articles, information on other centers, etc. under three main categories: policy and system concerns, program and process concerns, and specific psychosocial problems. (Updated regularly)*

Catalogue of Internet Sites Relevant to Mental Health in Schools

This catalogue contains a compilation of Internet resources and links related to addressing barriers to student learning and mental health in schools. (Updated regularly)*

Organizations with Resources Relevant to Addressing Barriers to Learning: A Catalogue of Clearinghouses, Technical Assistance Centers, and Other Agencies

This catalogue categorizes and provides contact information on organizations focusing on children's mental health, education and schools, school-based and school-linked centers, and general concerns related to youth and other health related matters. (Updated regularly)*

Where to Get Resource Materials to Address Barriers to Learning

This resource offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.*

III. Technical Aid Packets

School-Based Client Consultation, Referral, and Management of Care

This aid discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. It outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. It also provides discussion of prereferral intervention and referral as a multifaceted intervention. It clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. It also provides examples of tools to aid in all these processes ware included.*

School-Based Mutual Support Groups (For Parents, Staff; and Older Students)

This aid focuses on steps and-tasks related to establishing mutual support groups in a school setting. A sequential approach is described that involves (1) working within the school to get started, (2) recruiting members, (3) training them on how to run their own meetings, and (4) offering off-site consultation as requested. The specific focus here is on parents; however, the procedures are readily adaptable for use with others, such as older students and staff.*

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Volunteers to Help Teachers and School Address Barriers to Learning

This aid outlines (a) the diverse ways schools can think about using volunteers and discusses how volunteers can be trained to assist designated youngsters who need support, (b) steps for implementing volunteer programs in schools, (c) recruitment and training procedures and (d) key points to consider in evaluating volunteer programs. The packet also includes resource aids and model programs.*

Welcoming and Involving New Students and Families

This aid offers guidelines, strategies, and resource aids for planning, implementing, and evolving programs to enhance activities for welcoming and involving new students and families in schools. Programs include home involvement, social supports, and maintaining involvement.*

Guiding Parents in Helping Children Learn

This aid is specially designed for use by professionals who work with parents and other nonprofessionals, and consists of a "booklet" to help nonprofessionals understand what is involved in helping children learn. It also contains information about basic resources professionals can draw on to learn more about helping parents and other nonprofessionals enhance children's learning and performance. Finally, it includes additional resources such as guides and basic information parents can use to enhance children's learning outcomes.*

IV. Technical Assistance Samplers

Behavioral Initiatives in Broad Perspective

This sampler covers information on a variety of resources focusing on behavioral initiatives to address barriers to learning (e.g., state documents, behavior and school discipline, behavioral assessments, model programs on behavioral initiatives across the country, school wide programs, behavioral initiative assessment instruments, assessing resources for school-wide approaches).*

School-Based Health Centers (7/98)

This sampler includes information on a wide range of issues dealing with school-based health centers (e.g., general references, facts & statistics, funding, state & national documents, guides, reports, model programs across the country).*

V. Guides to Practice and Continuing Education Units -- Ideas into Practice

Mental Health and School-Based Health Centers

This revised guidebook is virtually a completely new aid. The introductory overview focuses on where the mental health facets of school-based health centers (SBHCs) fit into the work of schools. This is followed by three modules. Module I addresses problems related to limited center resources (e.g., limited finances) and how to maximize resource use and effectiveness); Module II focuses on matters related to working with students (consent, confidentiality, problem identification, prereferral interventions, screening/assessment, referral, counseling, prevention/mental health education, responding to crises, management of care); Module III explores quality improvement, evaluating outcomes, and getting credit for all you do. Each module is organized into a set of units with many resource aids (sample forms and special exhibits, questionnaires, interviews, screening indicators) for use as part of the day-by-day SBHC operational focus on mental health and psychosocial concerns. A coda highlights ways to and benefits of weaving together all resources for addressing barriers to student learning into a comprehensive, integrated approach.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

What Schools Can Do to Welcome and Meet the Needs of All Students and Families

This guidebook offers program ideas and resource aids that can help address some major barriers that interfere with student learning and performance. Much of the focus is on early-age interventions; some is on primary prevention; some is on addressing problems as soon after onset. The guidebook includes the following: Schools as Caring, Learning Environments, Welcoming and Social Support: Toward a Sense of Community Throughout the School; Using Volunteers to Assist in Addressing School Adjustment Needs and Other Barriers to Learning; Home Involvement in Schooling: Connecting a Student with the Right Help; Understanding and Responding to Learning Problems and Learning Disabilities; Response to Students' Ongoing Psychosocial and Mental Health Needs; Program Reporting: Getting Credit for All You Do and, Toward a Comprehensive, Integrated Enabling Component.

CONTINUING EDUCATION MODULES

Addressing Barriers to Learning: New Directions for Mental Health in Schools

This module consists of three units to assist mental health practitioners in addressing psychosocial and mental health problems seen as barriers to students' learning and performance. It includes procedures and guidelines on issues such as initial problem identification, screening/assessment, client consultation & referral, triage, initial and ongoing case monitoring, mental health education, psychosocial guidance, support, counseling, consent, and confidentiality.*

Mental Health in Schools: New Roles for School Nurses

The above three units have been adapted specifically for school nurses. A subset of the nursing material will appear in video/manual self-study format produced by National Association of School Nurses with support of the Robert Wood Johnson Foundation and National Education Association.*

Continuing Education Related to the Enabling Component

Classroom Focused Enabling

This module consists of guidelines, procedures, strategies, and tools designed to enhance classroom based efforts by increasing teacher effectiveness for preventing and managing problems in the classroom and helping address barriers to learning.

VI. Feature Articles from Our Newsletter*

Mental Health in Schools: Emerging Trends (Winter '96)

Presents an overview of the need to include a focus on mental health in schools as part of efforts to address barriers to student learning. Highlights emerging trends and implications for new roles for mental health professionals. Includes tables outlining the nature and scope of students' needs, the range of professionals involved, and the types of functions provided.

School-Linked Services and Beyond (Spring '96)

Discusses contributions of school-linked services and suggests it is time to think about more comprehensive models for promoting healthy development and addressing barriers to learning.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

Labeling Troubled and Troubling Youth: The Name Game (Summer '96)

Underscores bias inherent in current diagnostic classifications for children and adolescents and offers a broad framework for labeling problems so that transactions between person and environment are not downplayed. Implications for addressing the full range of problems are discussed.

Comprehensive Approaches & Mental Health in Schools (Winter '97)

Discusses the enabling component, a comprehensive, integrated approach that weaves six main areas into the fabric of the school to address barriers to learning and promote healthy development for *all* students.

Behavior Problems: What's a School to Do? (Spring '97)

Sheds light on the prevailing disciplinary practices in schools and their consequences for classroom management purposes. Beyond discipline and social skills training, the article underscores the need to look into the underlying motivational bases for students' misbehavior for intervention programs to take effect.

Enabling Learning in the Classroom: A Primary Mental Health Concern (Spring '98)

Highlights the importance of institutionalizing the *enabling component* in schools. Discusses how *classroom-focused enabling* (one of six clusters of programmatic activity) enhances the teacher's array of strategies for working with a wide range of individual differences (including learning and behavior problems) and creating a caring context for learning in the classroom.

*You may download the indicated documents through our website at: http://smhp.psych.ucla.edu

D. Consultation Cadre

UCLA Center for Mental Health in Schools

Consultation Cadre: Colleagues Helping Colleagues

As part of our Center's efforts to facilitate the sharing of information and skills, we have recruited a wide range of professionals to volunteer their expertise. To date, over 300 professionals have volunteered to network with others to share what they know. Cadre members have indicated expertise related to major system concerns, a variety of program and processing issues, and almost every type of psychosocial problem. They work in urban and rural areas across the country.

Who's on board? Some run programs (for example, one directs the Safe and Drug-Free Schools program for a state education agency). Many work directly with kids in a variety of settings and on a wide range of problems. Others are ready to share their expertise on policy, funding, and system changes (for example, one professor is enmeshed in developing a model for a statewide, school-based mental health system; another is involved with school restructuring).

Cadre members are not screened. It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to provide a way for you all to connect with each other. Using our website you can SEARCH our Consultation Cadre by topic for a list of members who are willing to assist you.

For additional assistance you may contact our center's Technical Assistance staff. Referrals to Cadre Members are provided as part of our daily technical assistance activity.

We are always looking for a few more good professionals. Our Consultation Cadre is composed of professionals who have relevant experience related to addressing barriers to student learning and mental health in schools. We want to include any of you with such expertise who are willing to be contacted and will provide a limited amount of free consultation. JOIN our Consultation Cadre.

For more information on the Consultation Cadre, contact the Center.